

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

CERTIFICATE OF DEATH

Reg. Diat. No. 30

1. PLACE OF DEATH: Baltimore County..... City or town..... Catonsville (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? 2 months, 19 days Hospital, institution, or street address where death occurred: Spring Grove State Hospital How long in hospital or institution? 2 months, 19 days		2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... Maryland County..... City or town..... Baltimore (If outside city or town limits, write RURAL and give nearest town) Street No..... 27 E. Hill Street (If rural, give LOCATION) 2.(a) If veteran, name war.....	
3. (a) FULL NAME Mary Alexander		3. (b) Social Security Number -	
MEDICAL CERTIFICATION			
4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single		2D. DATE OF DEATH February 15, 1947, at 9:30 pm	
6.(b) Name of husband or wife Single 7. Birth date of deceased (mo., day, yr.) Dec 5, 1897 6.(c) If alive, give age - years		21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 27, 1946, to February 15, 1947 and that I last saw her alive on February 15, 1947	
8. AGE: Years 59 Months 2 Days 10 If less than one day hrs. min.		Immediate cause of death Left Lower lobar pneumonia DURATION 3 days	
9. Birthplace Baltimore, Maryland (Town, county, and state)		Due to Arteriosclerotic cardiovascular disease Indef.	
10. Usual occupation at home		Due to	
11. Industry or business home		Other conditions	
12. Name Charles Alexander 13. Birthplace Germany 14. Maiden name Katie (P) 15. Birthplace unk Germany		(Include pregnancy within 3 months of death)	
16. Informant Hospital Records Address Baltimore 28, Maryland-1616		Major findings of operations	
17. Burial - Date thereof Feb 19, 1947 (Burial, cremation, or removal. Which?) Cemetery or crematory Glen Haven Ctry Location A. C. Co., Inc. 18. Funeral director P. Howard Evans Address 14008 Charlotte Blvd 30 md 1818 A. C. Co., Inc. 19. (Date rec'd by registrar) 2/18/47		22. PHYSICIAN: Please underline the code in which death should be charged statistically. 22. VIOLENCE If death was due to external causes, fill in the following: Accident, suicide, or homicide Date of Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury Injured at work? Isadore Tuerk, M.D. Catonsville 28, Md. M. D. or other 23. SIGNATURE A. C. Co., Inc. Registrar Address Date signed 2/17/47	

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County BaltimoreCity or town Towson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
119 Greenridge Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Towson
(If outside city or town limits, write RURAL and give nearest town)Street No. 119 Greenridge Road
(If rural, give LOCATION)2.(a) If veteran, name war ////////

3. (a) FULL NAME

WILLIAM CARVEL ALLEN

3. (b) Social Security Number

////////

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6.(a) Single, married, widowed, or divorced <u>Married</u>
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6.(b) Name of husband or wife Mary Louise Allen6.(c) If alive, give age 78 years7. Birth date of deceased (mo., day, yr.) July 21, 1868

8. AGE: <u>78</u>	Years	Months <u>6</u>	Days <u>19</u>	If less than one dayhrs.min.
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9. Birthplace Baltimore Co., Maryland
(Town, county, and state)10. Usual occupation Carpenter11. Industry or business General ContractorFATHER 12. Name Columbus Allen13. Birthplace MarylandMOTHER 14. Maiden name Amanda Corns15. Birthplace Maryland16. Informant Mrs. Mary L. AllenAddress 119 Greenridge Rd., Towson, Md.17. Burial Date thereof Feb. 12, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Asbury Methodist CemeteryLocation Reisterstown, Balto. Co., Md.18. Funeral director John Burns' SonsAddress Towson, Maryland19. 2/12/47 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9, 1947, at 2:00 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 1947 to Feb 8 1947
and that I last saw him alive on Feb 8 1947

Immediate cause of death

DURATION

Coronary Occlusion 2 daysDue to arterio-sclerosisDue to hypertension sub.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature Chas. Green M.D.

M. D. or other

Address Bowman - 4 - sub Date signed 2/10/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01332

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 100 days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Fort Howard, MarylandHow long in hospital or institution? 100 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 511 S. Bouldin St.
(If rural, give LOCATION)2. (a) If veteran, name war WW II

3. (a) FULL NAME

JOHN J. BEATTY

3. (b) Social Security Number

216-03-1296

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MaleWhiteMarried6. (b) Name of husband or wife Genevieve Beatty6. (c) If alive, give age 28 years7. Birth date of deceased (mo., day, yr.) 4-12-19098. AGE: Years Months Days If less than one day
37 8 - hrs. min.9. Birthplace Baltimore, Maryland
(Town, county, and state)10. Usual occupation Unemployed

11. Industry or business

12. Name James Beatty13. Birthplace Maryland14. Maiden name Annie Buettner15. Birthplace Maryland16. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Maryland17. Burial Date thereof FEB 17-1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore National CemeteryLocation Baltimore, Maryland18. Funeral director Ellsworth ArmacostAddress 3911 Liberty Heights Ave.19. 2/4 47 A. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH February 12 19 47 at 8:50 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
November 4 19 47 to February 12 19 47
and that I last saw him alive on February 12 19 47Immediate cause of death Primary bile duct Carcinoma with metastases to retroperitoneal lymph nodes, ribs and right humerus.
DURATION 3 MonthsDue to Chylous-ascites and chylous pleural effusion
Other conditions Unknown
(Include pregnancy within 3 months of death)Major findings of operations Substantiated above.
Date of op.Autopsy results Substantiated above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?23. SIGNATURE Robert M. Cullison
M. CULLISON, M.D. CLIN. M. DTPH
Address A.A. Ft. Howard, Md. Date signed 2-13-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

01377

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 9 yrs., 2 months, 11 days
 Hospital, institution, or street address where death occurred:
SPRING GROVE ST. Hosp.
 How long in hospital or institution? 9 yrs., 2 months, 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Baltimore
 City or town Towson
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 409 Delaware Avenue
 (If rural, give LOCATION)
 2. (a) If veteran, name war 1111

3. (a) FULL NAME

SYDNEY * BEAVAN

*George

3. (b) Social Security Number

111111

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Leila JARBOV
 6. (c) If alive, give age 75 years
 7. Birth date of deceased (mo., day, yr.) July 9th 1868
 8. AGE: Years 78 3/4 Months 7 Days 14 If less than one day _____ hrs. _____ min.

9. Birthplace Leonard town, St. Mary's County
 (Town, county, and state)
 10. Usual occupation Farmer
 11. Industry or business Retired
 12. Name Unknown
 13. Birthplace 11
 14. Maiden name Catherine Beaven
 15. Birthplace Unknown

16. Informant Mr. James M. Beavan
 Address 49 Delaware Ave., Towson, Md.
 17. Burial Date thereof Feb. 26, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Parkwood Cemetery
 Location Parkville, Maryland
 18. Funeral director John Burns' Sons
 Address Towson, Maryland
 19. 2/25 47 A. H. Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 23rd 1947 at 5:45 P.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 4th 1937 to Feb. 23rd 1947
 and that I last saw him alive on Feb. 23rd 1947
 Immediate cause of death cardiac failure
 DURATION 1 hour
 Due to Bronchio pneumonia 24.
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)
 Major findings of operations _____
 Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE _____ M. D. or other
 Address _____ Date signed _____

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 552

CERTIFICATE OF DEATH

01333

Reg. Dist. No. 30

1. PLACE OF DEATH: County..... <u>Balto.</u> City or town..... <u>Catonsville</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... Hospital, institution, or street address where death occurred: <u>33 S. Prospect Ave.</u> How long in hospital or institution?.....				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>Md.</u> County..... <u>Balto.</u> City or town..... <u>Catonsville</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... <u>33 S. Prospect Ave.</u> (If rural, give LOCATION) 2.(a) If veteran, name war.....			
3.(a) FULL NAME <u>OTILIE KATHERINE BELTZ</u>				3.(b) Social Security Number <u>none</u>			
4. Sex <u>Female</u>		5. Color or race <u>White</u>		6.(a) Single, married, widowed, or divorced <u>Widow</u>			
6.(b) Name of husband or wife <u>George William Beltz</u>							
7. Birth date of deceased (mo., day, yr.) <u>Dec. 4, 1887</u>							
8. AGE: <u>59</u>		Months <u>20</u>		Days <u>1</u>		If less than one day <u>hrs. min.</u>	
9. Birthplace <u>Baltimore, Md.</u> (Town, county, and state) 10. Usual occupation <u>Housewife</u>							
11. Industry or business FATHER 12. Name <u>Gottlieb G. Dieterich</u> 13. Birthplace <u>Germany</u> MOTHER 14. Maiden name <u>Nanneth C. Vogelmann</u> 15. Birthplace <u>Germany</u>							
16. Informant <u>Mr. George W. Beltz, Jr.</u> Address <u>33 S. Prospect Ave., Catonsville</u>							
17. Burial (Burial, cremation, or removal. Which?) Date thereof <u>2/8/47</u> (month) (day) (year) Cemetery or crematory <u>Oaklawn Cem.</u> Location <u>Balto., Md.</u>							
18. Funeral director <u>WM. J. TICKNER & SONS</u> Address <u>Balto., Md.</u>							
19. <u>2/7</u> <u>47</u> (Date rec'd by registrar) 19							
20. DATE OF DEATH <u>Feb. 5,</u> 19 <u>47</u> at <u>5:05a</u> M							
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>12/23</u> 19 <u>46</u> to <u>2/5</u> 19 <u>47</u> and that I last saw him/her alive on <u>2/4</u> 19 <u>47</u> Immediate cause of death <u>Symphosarcoma</u> <u>General Metastasis</u> <u>Symphosarcoma Rt Inguinal Gland</u> Due to <u>Gland</u> Due to Other conditions (Include pregnancy within 3 months of death) <u>Mesob Rt Inguinal Gland</u> <u>Symphosarcoma</u> Date of op. <u>9/18/46</u> Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.							
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury Injured at work?							
23. SIGNATURE <u>Eliot W. Johnson</u> <u>3432 Induchane</u> Address..... Date signed <u>2/6/47</u>							

Registrar

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

01334

440

1. PLACE OF DEATH:

County Baltimore
City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 Days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland
How long in hospital or institution? 17 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 330 E. 21st. Street
(If rural, give LOCATION)
2. (a) If veteran, name war SAW

3. (a) FULL NAME

JESSE BENNETT

3. (b) Social Security Number

265-09-4042

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Louise Bennett
6. (c) If alive, give age 60 years
7. Birth date of deceased (mo., day, yr.) 7-23-1879
8. AGE: Years 67 Months 6 Days 13 If less than one day _____ hrs. _____ min.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 6, 19 47 2:45 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 20, 19 47 to February 6, 19 47
and that I last saw him alive on February 6, 19 47
Immediate cause of death Carcinoma of Stomach, bleeding DURATION 4 Weeks
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

9. Birthplace Red Bluff, Cal
(Town, county, and state)
10. Usual occupation Race Track Custodian
11. Industry or business _____
12. Name James Bennett
13. Birthplace Kentucky
14. Maiden name Emma Preston
15. Birthplace England

16. Informant Clinical Records, Vets. Adm. Hosp.
Address Fort Howard, Maryland

17. Burial Date thereof 2-10-47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory U.S. National (Baltimore)
Location Baltimore, Md.

18. Funeral director STEWART & MOWEN COMPANY
Address (W. F. WOODEN SQ.) 100 W. NORTH AVENUE

19. (Date rec'd by registrar) 2/7 X? A.W. Hedrick Registrar

Major findings of operations _____ Date of op. _____
Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work?

23. SIGNATURE Robert M. Cullison
R.M. CULLISON, M. D. CLIN. DIRECTOR
Address V.A. Ft. Howard, Md. Date signed 2-6-47

MARGIN RESERVED FOR BINDING

9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 12. 1947
BUREAU 3

STEWART & HOBBS COMPANY
100 N. 1st St. - 1st Floor

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 387

1. PLACE OF DEATH:

County BaltimoreCity or town Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 Yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ma. County Balto:City or town Towson

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1001 West Joppa rd.

If rural, give LOCATION

2.(a) If veteran, name war:

3. (a) FULL NAME

Sister M. Berchmans (Margaret Mary Mc.Loughlin)

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

B. (b) Name of husband or wife:

None

7. Birth date of

deceased (mo., day, yr.) April 15th., 1891

6. (c) If alive, give age..... years

8. AGE:

55

Years

Months

9

Days

27

If less than one day

#####

min.

9. Birthplace Ireland

(Town, county, and state)

10. Usual occupation:

Religious

11. Industry or business

12. Name John McLoughlin

13. Birthplace

Ireland

14. Maiden name

Anne Connor

15. Birthplace

Ireland16. Informant Mission Helpers RecordsAddress 1001 West Joppa road, Towson Md.

17. Burial

Date thereof 2/14/47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Mission Helpers cemetery

Location

1001 W. Joppa road, Towson, Md.

18. Funeral director

George J. Ruth, Inc.

Address

1735 Harford Avenue

19.

(Date rec'd by registrar)

19

Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH 2/12/47 19. 11 50 at pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov.19. 46

to

2-12-47

19.

and that last saw him alive on 2-11-47 19.

Immediate cause of death

Heart disease
Coronary Arteriosclerosis

DURATION

ys.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H. Quinn

M. D. or other

Address

4 Park View St. TowsonDate signed 12-16-47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (837)

CERTIFICATE OF DEATH

Reg. Dist. No. 57

01336

1. PLACE OF DEATH:

County Baltimore
 City or town Sparks (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Lifetime
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Sparks (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. York Rd.
 (If rural, give LOCATION)
 2(a) If veteran, name war none

3. (a) FULL NAME

Thomas E. Billingsley

3. (b) Social Security Number

none

4. Sex

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Sattie (nee Curry)

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age 73 years
Nov. 11, 1869

8. AGE:

Years

Months

Days

If less than one day

77125

hrs.

min.

9. Birthplace

Balto Co., Md.
(Town, county, and state)

10. Usual occupation

Farmer (retired 5 yrs)

11. Industry or business

FATHER

12. Name

Samuel Billingsley

13. Birthplace

Balto Co., Md.

MOTHER

14. Maiden name

Sarah E. Staller

15. Birthplace

Balto Co., Md.

16. Informant

Mrs. Mrs. E. Billingsley

Address

Sparks, Md.

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

Feb 7, 1947
(month) (day) (year)

Cemetery or crematory

Monkton Meth Church

Location

Monkton, Md.

18. Funeral director

Sandon M. Brooks

Address

Sparks, Md.

19.

2-5
(Date rec'd by registrar)

19.

47Wilmer C. Ensor

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5 19 47, at 10:55 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 38 to Feb. 3 19 47
 end that I last saw him alive on Feb. 4 19 47

Immediate cause of death

Cerebral Thrombosis

DURATION

Due to

Due to

Other conditions

Arterio-sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

G. M. France

M. D. or other

Address Paulston, Md. Date signed 2/5/47

RECEIVED

FEB 7 1947

BUREAU V.B.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlea St., Baltimore

832

01337

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:

County BaltimoreCity or town Owings Mills
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? LifeHospital, institution, or street address where death occurred:
Rosewood Lane

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Owings Mills
(If outside city or town limits, write RURAL and give nearest town)Street No. Rosewood Lane
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Albert Eugene Bleakley

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Katherine Bleakley6.(c) If alive, give age 78 years7. Birth date of deceased (mo., day, yr.) November 23, 18658. AGE: Years 81 Months 3 Days 19 If less than one day
.....hrs.min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Laborer

11. Industry or business

12. Name Sam. H. Bleakley13. Birthplace Maryland14. Maiden name Mary Marshall15. Birthplace Ireland16. Informant Mrs. Katherine Bleakley (wife)Address Rosewood La., Owings Mills, Md.17. Burial Date thereof Feb. 15, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. ThomasLocation Balto. Co.18. Funeral director J. F. Eline & SonsAddress Rustictown rd.19. 2-12- 1947 Dr. E. E. Nichols
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 12, 1947, at 9:05-AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Sept. 10, 1946 to Feb. 12, 1947and that I last saw him alive on Feb. 12, 1947Immediate cause of death Cerebral Hemorrhage DURATION 5 mo.Due to Arterio sclerosis

Due to

Other conditions Senility

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. E. Nichols M. D. or otherAddress Pikesville-8, Md. Date signed 2/12/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 14 1947

BERKLEY

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3d)

CERTIFICATE OF DEATH

01338

Reg. Dist. No. 301

1. PLACE OF DEATH:

County Baltimore

City or town Eatonville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Opitz House - Edmondson Ave. Nunnery

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County

City or town Arbutus
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1229 North Ave
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Jennie Blocher

3. (b) Social Security Number

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife Christian Blocher

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 16 - 1865

8. AGE: Years 81 Months 11 Days 9 If less than one day
hrs. min.

8. Birthplace Luxembourg
(Town, county, and state)

10. Usual occupation House Wife

11. Industry or business

12. Name Pierre Fiedler

13. Birthplace Luxembourg

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Mrs. Simpson

Address Wash. D. C.

17. Burial Date thereof Feb 28, 1947
(Burial, cremation, or removal Which?) (month) (day) (year)

Cemetery or crematory Western

Location City

18. Funeral director Mrs. John W. Tupper & Son

Address 5311 Edmondson Ave

19. 2-27- 19 47 Harry L. Miller
(Date rec'd by registrar) (year) (month) (day) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 25 19 47 at 7:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 19 46 to Feb 25 19 47
and that I last saw him alive on Feb 25 19 47

Immediate cause of death Chr. Thyroiditis

DURATION

2 mon

Due to Arterio Sclerosis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Jennie Stowell M. D. or other

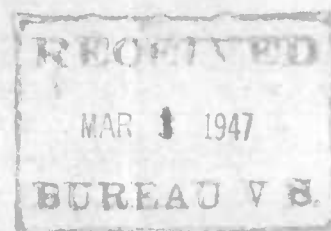
Address Arbutus Date signed 2/26

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Rel 7132 -



1 - 35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. (For correct age is especially important. Physicians: please write the causes of death clearly and legibly.)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (163-74)

CERTIFICATE OF DEATH

01339

Reg. Dist. No. 430

1. PLACE OF DEATH:

County Baltimore
 City or town Respecting Balto #6
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

300 Dale Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County Balto.City or town Balto #6
(If outside city or town limits, write RURAL and give nearest town)Street No. 300 Dale Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Evelyn Shipley Blondell

3. (b) Social Security Number

4. Sex

Fem.

5. Color or race

W.

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Wm. J. Blondell

6.(c) If alive, give age.....years

7. Birth date of

deceased (mo., day, yr.)

Oct. 10th 1907

8. AGE:

Years

Months

Days

If less than one day

3948

hrs.

min.

9. Birthplace

Balto. Md.

(Town, county, and state)

10. Usual occupation

at home

11. Industry or business

FATHER

12. Name

Floyd M. Shipley

13. Birthplace

Balto. Md.

MOTHER

14. Maiden name

Bessie Booker

15. Birthplace

Va.

16. Informant

Wm. J. Blondell

Address

300 Dale Ave.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

2/21/47
(month) (day) (year)

Cemetery or crematory

Green Haven

Location

Anne Arundel Co.

18. Funeral director

Lassahn Funeral Home

Address

7401 Belair Rd.

19. Feb. 19

(Date rec'd by registrar)

19. 47

Wm. G. L. Reifman

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 18, 1947, at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw h.....alive on.....19.....

Immediate cause of death

Monoxide Poisoning
(Gas)

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

at home

Means of injury

hooking GasInjured at work? no

23. SIGNATURE

Address

Wm. G. L. Reifman, M.D.
Deputy Medical Examiner

Date signed

Dental Mt.

RECEIVED
FEB 26 1947
BUREAU V.B.

2-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

01340

381

1. PLACE OF DEATH:

County BALTIMORECity or town TOWSON
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

SHEPPARD AND ENOCH PRATT HOSPITALHow long in hospital or institution? Since May 8, 1942

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town Easton
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

BOLLING, Mrs. Irene Johnson

3. (b) Social Security Number

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
-------------------------	----------------------------------	--

6. (b) Name of husband or wife George Melville Bolling6. (c) If alive, give age 76 years7. Birth date of deceased (mo., day, yr.) August 28, 1860

8. AGE:	Years	Months	Days	If less than one day
	<u>86</u>	<u>6</u>		hrs. min.

9. Birthplace Little Rock, Arkansas
(Town, county, and state)10. Usual occupation None

11. Industry or business

FATHER	12. Name <u>James B. Johnson</u>
	13. Birthplace <u>Kentucky</u>

MOTHER	14. Maiden name <u>Mary Pope Cooke</u>
	15. Birthplace <u>Kentucky</u>

18. Informant HOSPITAL RECORDS

Address

17. Burial Date thereof March 3/47
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory New Cathedral CemeteryLocation Elmwood Ave. Old Fort18. Funeral director John O. Mitchell & SonsAddress 1400 Easton Place19. 3/3/47 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 28, 1947 at 9:55 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 13, 1946 to February 28, 1947 and that I last saw her alive on February 28, 1947Immediate cause of death Chronic myocarditis with myocardial degeneration

DURATION

5 yrs +Due to Generalized arteriosclerosis 10 yrs +

Due to _____

Other conditions Senile Psychosis 5 yrs +

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results Autopsy not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Harry M. Murdock

Harry M. Murdock, M.D. M. D. or other

Address TOWSON, MARYLAND Date signed 3/1/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

01341

Reg. Dist. No. 387

1. PLACE OF DEATH:

County Baltimore
 City or town Bentley Springs
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 34 yrs.
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Bentley Springs
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Nina May Bollinger.

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White Widow.

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

Daniel H. Bollinger

7. Birth date of deceased (mo., day, yr.)

August 2, 1882.

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

6467

hrs.

min.

9. Birthplace

Glen Rock, Pa. R.D.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own home

FATHER

12. Name

Jefferson Sutton

13. Birthplace

Harford Co., Md.

MOTHER

14. Maiden name

Elizabeth Cooper

15. Birthplace

York Co., Penna.

16. Informant

Mrs Benjamin Cummings

Address

Bentley Springs, Md.

17.

(Burial, cremation, or removal, Which?)

Date thereof

Feb. 9, 1947
(month) (day) (year)

Cemetery or crematory

Mt. Zion

Location

Freeland, Md.

18. Funeral director

Jacob Harkness

Address

New Freedom, Pa.

19.

(Date rec'd by registrar)

Feb. 111947Chas. L. Green
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9, 1947, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 1, 1947, to Feb. 7, 1947and that I last saw him alive on Feb. 8, 1947

Immediate cause of death

Chs. Cardio-vascular renal disease.

DURATION

4 yrs.

Due to

Due to

Other conditions

Diabetes Mellitus6 yrs.

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

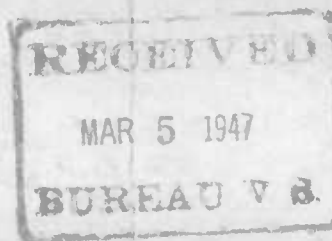
23. SIGNATURE

Paul D. Shaw, M.D.

M. D. or other

Address

Shrewsbury, Pa.Date signed 2-10-47



2-25

2-350 — 2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. M. Bowman Hood

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01342

P

(83a) *

CERTIFICATE OF DEATH

Reg. Dist. No. 381

1. PLACE OF DEATH:County TowsonCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

502 Dunkirk Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TowsonCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 502 Dunkirk Road
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAMEAgnes M. Bopp**3. (b) Social Security Number**

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<u>female</u>	<u>white</u>	<u>widowed</u>

6. (b) Name of husband or wife John J. Bopp

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) July 1, 1872

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>7</u>	<u>3</u>hrs.min.

9. Birthplace Canada
(Town, county, and state)10. Usual occupation at home

11. Industry or business

12. Name John J. Kelly13. Birthplace England14. Maiden name Margaret Handley15. Birthplace Ireland16. Informant Mrs. Oliver G. BarnardAddress 502 Dunkirk Road,17. Burial Date thereof 2/7/47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Holy CrossLocation Brooklyn, Maryland18. Funeral director Leonard J. RuckAddress 5305 Harford Road, 14..19. Feb. 6 19 47 R. W. Hedrick
(Date rec'd by registrar) Registrar**MEDICAL CERTIFICATION**20. DATE OF DEATH February 4th, 19 47 at 8:40 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 13 19 47 to Feb. 4 19 47 and that I last saw ex alive on Feb 4 19 47

Immediate cause of death.....

DURATION

Cerebral Palsy - 6 daysDue to Artificial respiration & hyperventilation second year

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE M. Bowman Hood M. D. or otherAddress 2200 Garrison Blvd Date signed Feb 5/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (52-6)

CERTIFICATE OF DEATH

Reg. Dist. No. 330

01343

1. PLACE OF DEATH:

County Balto.City or town Near Reisterstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 24 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Near Reisterstown
(If outside city or town limits, write RURAL and give nearest town)Street No. Ridge Road Chestnut Ridge
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Thomas Edward Bosley

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Savilla Bosley6. (c) If alive, give age years7. Birth date of deceased (mo., day, yr.) Sept. 18, 1864

8. AGE:

Years

82

Months

4

Days

21

If less than one day

 hrs. min.9. Birthplace Balto. Co.

(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

12. Name John Bosley13. Birthplace Balto. Co.14. Maiden name Mary Talbert15. Birthplace Balto. Co.16. Informant Mrs. Savilla BosleyAddress Reisterstown, Md.17. Burial Date thereof Feb. 12, 1947
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Pine Grove U.B.Location Balto. Co.18. Funeral director J.F. Eline & SonsAddress Reisterstown, Md.19. Feb. 11 - 1947
(Date rec'd by registrar)J.F. Eline
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 8th 1947, at 4 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 10 1946 to Feb. 7 am 1947 and that I last saw him alive on Feb 7 1947

Immediate cause of death

Carcinoma of Bladder
Infective CystitisDue to AsbestosDue to Arterio-sclerosisChronic Nephritis

Other conditions

(Include pregnancy within 3 months of death)

Major findings at operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Cyril E. Towble M.D.
M. D. or otherAddress Upperco, Md. Date signed Feb 10 1947

DURATION

1 yr10 yrs

CERTIFICATE OF DEATH

1. Name of deceased

2. Date of death

3. Place of death

4. Cause of death

5. Manner of death

6. Age at death

7. Sex

8. Race

9. Marital status

10. Occupation

11. Education

12. Date of birth

13. Date of death

14. Date of death

15. Date of death

16. Date of death

17. Date of death

18. Date of death

19. Date of death

20. Date of death

21. Date of death

22. Date of death

23. Date of death

24. Date of death

25. Date of death

26. Date of death

27. Date of death

28. Date of death

29. Date of death

30. Date of death

31. Date of death

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33. Date of death

34. Date of death

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37. Date of death

38. Date of death

39. Date of death

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41. Date of death

42. Date of death

43. Date of death

44. Date of death

45. Date of death

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48. Date of death

49. Date of death

50. Date of death

51. Date of death

52. Date of death

53. Date of death

54. Date of death

55. Date of death

56. Date of death

57. Date of death

58. Date of death

59. Date of death

60. Date of death

61. Date of death

62. Date of death

63. Date of death

RECEIVED

FEB 13 1947

BUREAU 15

1-35-

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Evidence for change of age shown on film 109-3/19/47

STATE OF MARYLAND—CERTIFICATE OF DEATH

★1344

1. PLACE OF DEATH

County

Baltimore

Village or City

Bridgetown

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

2. FULL NAME

Louis Edward Broadway

(a) Residence: No.

Off Pulaski Highway, Gunpowder Falls, Baltimore

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Colored

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Amelia Broadway

6. DATE OF BIRTH (month, day, and year)

Apr 11/1885

7. AGE

Years

Months

Days

If LESS than

61 62

10

16

1 day, hrs.
or min.

OCCUPATION

8. Trade, profession, or particular
kind of work done, as SPINNER,
SAWYER, BOOKKEEPER, etc.

Laborer

9. Industry or business in which
work was done, as SILK MILL,
SAW MILL, BANK, etc.10. Date deceased last worked at
this occupation (month and
year)11. Total time (years)
spent in this
occupation12. BIRTHPLACE (city or town)
(State or country)

Harford Co. Md.

FATHER

13. NAME

Joe Broadway

14. BIRTHPLACE (city or town)
(State or country)

Harford Co. Md.

MOTHER

15. MAIDEN NAME

Sarah Stevenson

16. BIRTHPLACE (city or town)
(State or country)

Harford Co. Md.

17. INFORMANT

(Address)

Amelia Broadway
Bridgetown Md.

18. BURIAL, CREMATION, OR REMOVAL

Place

Mt. Calvary

Date

3/4/47

19. UNDERTAKER

(Address)

Elroy O. Wilson
1000 Broadway Ave.

20. FILED

3-4 47

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

July 27/47

(Month)

(Day)

(Year)

22.

I HEREBY CERTIFY, That I attended deceased from

July 27/47, to July 27/47

I last saw him alive on

30/47

; death is said

to have occurred on the date stated above, at 2 PM.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Coronary occlusion

Date of onset

Other Contributory Causes of importance:

Carcinoma stomach

Sept 146. operation

Name of operation

at J.H.A.

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide?

Date of injury

19

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

J. M. Barman

M. D.

(Address)

Deputy Medical Examiner

Baltimore, Md.

If more blanks are needed, address State Registrar, 241 N. Charles Street, Baltimore, Md.

1-35

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>
Other contributory causes of importance:	
<i>Gallstones</i>	<i>May 1, 1923</i>

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>
Other contributory causes of importance:	
<i>Gastroenteritis</i>	<i>1 year</i>

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

01345

Reg. Dist. No. 330

1. PLACE OF DEATH:

County Baltimore
 City or town Owings Mills
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 yrs 8 mos
 Hospital, institution, or street address where death occurred:

Rosewood State Training School, Owings Mills, Md.

How long in hospital or institution? 9 yrs 8 mos

3. (a) FULL NAME

Lois Brown

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

May 20, 1930

8. AGE:

Years

Months

Days

If less than one day

16

9

1

hrs.

min.

9. Birthplace

Brookings, Md.
 (Town, county, and state)

10. Usual occupation

Inmate, Rosewood State Train

11. Industry or business

School, Owings Mills, Md.

12. Name

Ralph Brown

13. Birthplace

Garrett Co.

14. Maiden name

Marie Puff

15. Birthplace

Garrett Co.

16. Informant

Institutional Records; Rosewood

Address

State Training School, Owings Mills

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

Feb. 25-47

Cemetery or crematory

Rosewood

Location

Balto Co.

18. Funeral director

J. F. Elmer, Sons

Address

Pentuxtown, Md.

19.

2-25-47

(Date rec'd by registrar)

Nancy B. Elmer

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Brookings
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Route 2
 (If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21 19 47, at 11:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 17 19 47 to Feb 21 19 47

and that I last saw him alive on Feb 21 19 47

Immediate cause of death

Bronchopneumonia

DURATION

2 da

Due to Acute Bronchitis

4 da

Due to _____

Other conditions Congenital Epileptic

Life

which known

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. none

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? none

(City or town) (County) (State)

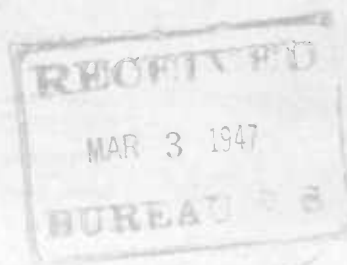
Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE George C. Suckair, M. D.

Address Owings Mills, Md.

Date signed 2/21/47



2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 440

1. PLACE OF DEATH

County Baltimore, Monocacy R. & R.City or town Rural Baltimore
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Essex, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. Bx. 283 R. 16 Essex 21, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war

no

3. (a) FULL NAME

Charles Brundick (Charles Brundick) 212-17-4387

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

M

6. (b) Name of husband or wife

Caroline Rathgeber Brundick6. (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.)

June 21, 1903

8. AGE:

Years

43

Months

8

Days

7

If less than one day

hrs. min.

9. Birthplace

Baltimore, Maryland

(Town, county, and state)

10. Usual occupation

11. Industry or business

American Oil Co.

FATHER

12. Name

Robert Brundick

13. Birthplace

Baltimore, Maryland

MOTHER

14. Maiden name

Elizabeth Henning

15. Birthplace

Baltimore, Maryland

16. Informant

Mrs. Caroline Brundick - widowAddress 283 R. 16 Baltimore - 21, Md.

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof 3/3/47

(month) (day) (year)

Cemetery or crematory

Trinity Cemetery

Location

Baltimore, Maryland

18. Funeral director

HENRY SANDER & SONS, INC.

Address

NORTH AVE. & BROADWAY

19.

March 1, 19 47

(Date rec'd by registrar)

A. H. Heflick

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

2/28 19 47 at 3:10 P M

that death occurred on the date above stated; that I attended deceased from

7/12 19 46 to 2/28 19 47

and that I last saw him alive on

2/28 19 47

Immediate cause of death

Cerebral hemorrhage

DURATION

1 w 6 d

Due to

Hypertensive C-V Disease2 y 4 mo

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

A. L. Kolodny MD

or other

Address

45 Edgewater Apt 47Date signed 2/28/47Baltimore 21, Md

MARGIN RESERVED FOR BINDING

VS-A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING-INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82a)

CERTIFICATE OF DEATH

01347

Reg. Dist. No. 43

1. PLACE OF DEATH:

County Baltimore
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, institution, or street address where death occurred:
5225 Hamilton Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5225 Hamilton
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

John G.F. Buchwald
4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced Widower

3. (b) Social Security Number

6.(b) Name of husband or wife Elizabeth Graf
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1858
8. AGE: Years 88 Months 3 Days 9 If less than one day
.....hrs.min.

8. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Butcher

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant Mr. Melvin Koppelman
Address 3000 Frankford Ave.

17. Burial Date thereof Feb. 10, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Jerusalem
4603 Belair Rd.

Location

18. Funeral director Lassahn Funeral Home
Address 7401 Belair Road.

19. Feb. 8 19 47 Mr. J.L. Ruffin
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7th 19 47 at 6 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 6 19 47 to Feb. 7 19 47
and that I last saw him alive on Feb. 6 19 47

Immediate cause of death Cerebral Hemorrhage
DURATION 2 days

Due to Arterio Sclerosis many yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Max R. English M.D.

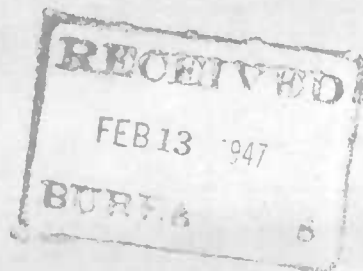
Address 5713 Belair Rd. Balt. Date signed 2-7-47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d 01348
Reg. Dist. No. 300

1. PLACE OF DEATH: Baltimore
County.....
City or town.....Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs., 1 month, 12 days
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 5 yrs., 1 month, 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State.....Maryland..... County.....
City or town.....Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.....3330 Gilman Terrace
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3.(a) FULL NAME Josephine Burdette 3.(b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife.....David W. Burdette

7. Birth date of deceased (mo., day, yr.) July 6, 1868 6.(c) If alive, give age..... years

8. AGE: Years 78 Months 7 Days 4 If less than one day..... hrs. min.

9. Birthplace.....Virginia
(Town, county, and state)

10. Usual occupation.....Unemployed

11. Industry or business.....None

12. Name.....Charles Edward Ross

13. Birthplace.....New York

14. Maiden name.....Sarah Catherine Hackley

15. Birthplace.....Virginia

16. Informant.....Hospital records

Address.....Catonsville-28, Maryland

17. Burial. Date thereof.....February 12/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....Poplar Springs.

Location.....Howard County.

18. Funeral director.....Chenoweth & Donovan.

Address.....3615-17 Chestnut Ave. 11.

19. (Date rec'd by registrar) 2-14-47 Registrar Isadore Tuerk

MEDICAL CERTIFICATION

2D. DATE OF DEATH.....February 10..... 19..47..... at 3:00 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 29..... 19..41..... to February 10..... 19..47..... and that I last saw her..... alive on..... February 10..... 19..47.....

Immediate cause of death.....Chronic myocarditis..... DURATION.....indefinite

Due to.....Generalized arteriosclerosis..... ".....

Due to.....

Other conditions.....Terminal parotitis, left..... 48 hrs.
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

SIGNATURE.....Isadore Tuerk, M.D...... M. D. or other

Address.....Catonsville-28, Maryland..... Date signed.....2-10-47

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

01349 P

1. PLACE OF DEATH

County Balts.Village or City EssexRegistration Dist. No. 942No. 942St. PP

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S. if of foreign birth? _____ yrs. _____ mos. _____ ds.

2. FULL NAME

William A. Burdette(a) Residence: No. Box 74, Rt. 16, Golden Ring, PHILA. RD.

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WIDOWED,
OR DIVORCED (write the word)married5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE ofANNA SAHLMAN

6. DATE OF BIRTH (month, day, and year)

JUNE 3rd 1890

7. AGE

Years

56

Months

8

Days

4If LESS than
1 day, _____ hrs.
or _____ min.

OCCUPATION

8. Trade, profession, or particular
kind of work done, as SPINNER,
SAWYER, BOOKKEEPER, etc.Real Estate Collector9. Industry or business in which
work was done, as SILK MILL,
SAW MILL, BANK, etc.10. Date deceased last worked at
this occupation (month and
year)11. Total time (years)
spent in this
occupation12. BIRTHPLACE (city or town)
(State or country)Montgomery Md

FATHER

13. NAME

JOHN. W.14. BIRTHPLACE (city or town)
(State or country)HOWARD Co MD

MOTHER

15. MAIDEN NAME

CELESTIAL MULLINIX16. BIRTHPLACE (city or town)
(State or country)HOWARD Co MD

17. INFORMANT

(Address) Box 74-Rt 16 Phila Rd.

18. BURIAL, CREMATION, OR REMOVAL

Place SchwartzDate 7/11, 1947

19. UNDERTAKER

(Address) Clarence F. Hoffmann

20. FILED

2-10-67 Arthur L. Smith

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

July 7, 19347
(Month) (Day) (Year)

22.

I HEREBY CERTIFY That I attended deceased from

July 7, 1947, to July 7, 1947

I last saw him alive on _____, 19____; death is said

to have occurred on the date stated above, at 2:00 p.m.The PRINCIPAL CAUSE OF DEATH and related causes of importance
were as follows:Coronary Occlusion

Date of onset

Other Contributory Causes of Importance:

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

(Address)

Dr. M. C. ...
Deputy Medical Examiner

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
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Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

3313

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 720

CERTIFICATE OF DEATH

01350
44
Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore
City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 Days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland
How long in hospital or institution? 3 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County _____
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 533 N. Vincent Street
(If rural, give LOCATION)
WW-1
2.(a) If veteran, name war _____

3. (a) FULL NAME

JOHN O. BURLEY

3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single
6. (b) Name of husband or wife Single
7. Birth date of deceased (mo., day, yr.) 8-23-95 6. (c) If alive, give age _____ years
8. AGE: Years 51 Months 5 Days 17 If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business _____
FATHER 12. Name John Burley
13. Birthplace Maryland
MOTHER 14. Maiden name Sarah Queen
15. Birthplace Maryland

16. Informant Clinical Records, Vets. Adm. Hosp.
Address Fort Howard, Maryland

17. Burial Date thereof Feb. 14, 1947
(Burial, cremation, or removal, which) (month) (day) (year)
Cemetery or crematory Balto. National Cem.

Location _____
18. Funeral director Mrs. Kate R. Williams
Address 322 N. Schroeder St.
Wm 49

19. (Date rec'd by registrar) _____ 19 47
Registrar _____

MEDICAL CERTIFICATION

20. DATE OF DEATH February 10, 19 47 at 1:05 a. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 7, 19 47 to February 10, 19 47
and that I last saw him alive on February 10, 19 47

Immediate cause of death Rheumatic endocarditis of mitro
and aortic valve with insufficiency and
xxx heart failure

DURATION
6 Mos.

Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
Autopsy results Substantiated above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____

23. SIGNATURE Robert M. Cullison
R. M. CULLISON, M.D. CLIN. DIR.
Address V.A. FT. HOWARD, MD. Date signed 2-10-47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 01351 300

1. PLACE OF DEATH:

County Balto.City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

106 Fairfield Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)Street No. 106 Fairfield Drive
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

NELLIE L. BURNS

3. (b) Social Security Number

4. Sex

female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widow

8. (b) Name of husband or wife

Thomas J. Burns

7. Birth date of

deceased (mo., day, yr.)

March 6, 1868

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

78

11

17

hrs.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name

Frank J. Flannery

13. Birthplace

Baltimore, Md.

14. Maiden name

Sarah Bupp

15. Birthplace

Baltimore, Md.

16. Informant Mr. Frank A. Burns

Address

106 Fairfield Drive, Catonsville

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

2/26/47

(month) (day) (year)

Cemetery or crematory New Cathedral Cem.Balto., Md.

Location

18. Funeral director WM. J. TICKNER & SONS

Address

Balto., Md.

19.

(Date rec'd by registrar)

19

2/26 47D. W. Hedrick

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23, 19 47, at 1:30 p.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Feb 1519 47to Feb 2319 47and that I last saw h. live on Feb 2319 47

Immediate cause of death

Chr. Myocarditis

DURATION

2 Mon

Due to

Arterio Sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Dist. No. 01352 401

1. PLACE OF DEATH:

County Baltimore Co.
 City or town Hyde Park, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 yrs.
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Raymond H. Burton

3. (b) Social Security Number

218-10-37144. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife

Ruth Alena Burton7. Birth date of deceased (mo., day, yr.) Jan 18 - 1894 8. (c) If alive, give age _____ years8. AGE: Years 53 Months 1 Days 5 If less than one day _____ hrs. _____ min.9. Birthplace Md. (Town, county, and state)10. Usual occupation Salvage material Martin

11. Industry or business

12. Name Chas. O. Burton13. Birthplace Md.14. Maiden name Rosa Schmarl15. Birthplace Md.16. Informant Mrs. Ruth Alena BurtonAddress Hyde Md.17. Burial Date thereof Feb. 25 - 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Paul's Chapel CmnLocation Greenwood Md.18. Funeral director G. E. ArthurAddress Fork Md.19. Feb. 24 1947 G. E. Arthur

(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Baltimore
 City or town M. Fork Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Hyde R. S. S.
 (If rural, give LOCATION)

2. (a) If veteran, name war _____

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22 1947 at 7:35 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5 1946 to Feb. 22 1947and that I last saw him alive on February 22 1947Immediate cause of death Cerebral Hemorrhage DURATION 5 hrs.Due to HypertensiveDue to Cardiovascular Disease 4 yrs.Other conditions Coronary Sclerosis

(Include pregnancy within 6 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Clifford F. Lindsoy MD

M. D. or other _____

Address W. Fork, Md. Date signed 2/23/47

RECEIVED

FEB 27 1947

BUREAU OF

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Evidence for the change of age is shown
on G 108 2/17/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 320

1. PLACE OF DEATH:

County Baltimore
City or town Pikesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Balto
City or town Pikesville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1102 Pikesville Rd.
(If rural, give LOCATION)
2(a) If veteran, name war

3. (a) FULL NAME

Mary Elizabeth Bushmiller

3. (b) Social Security Number

none

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced Widow

6. (b) Name of husband or wife Joseph H. Bushmiller
Deceased

7. Birth date of deceased (mo., day, yr.) July 2 - 1893 8. (c) If alive, give age, years

8. AGE: Years 51 Months 4 Days 8 It less than one day
hrs. min.

9. Birthplace Kingsston N.Y.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Michael Flannery

13. Birthplace Kingsston N.Y.

14. Maiden name Margaret Ann Kiernan

15. Birthplace Kingslon N.Y.

16. Informant Mrs. Oscar Millman

Address 5205 Garmouth Rd. Balto. Md.

17. Burial, cremation, or removal, Which? Burial Date thereof Feb 14 - 1947
(month) (day) (year)

Cemetery or crematory New Cathedral

Location Fredrick Rd. Balto. Md.

18. Funeral director Frank H. Gurell

Address Pikesville, Maryland

19. Feb 11 1947 B. E. Nichols
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 10, 1947, at 3 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 8 1947 to Feb 10 1947
and that I last saw him alive on Feb 9th 1947

Immediate cause of death

Pulmonary Tuberculosis

Due to Pulmonary Tuberculosis

Due to Pulmonary Tuberculosis

Other conditions Cystitis
Hemorrhoids
(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Louis T. Adams
M. D. or other

Address Pikesville Date signed 2/10/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

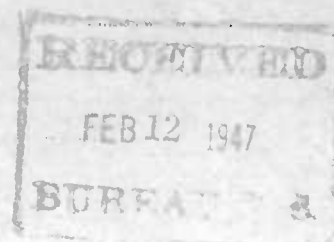
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FEB 13 1947

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

01355

1. PLACE OF DEATH:

County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 43 yrs., 1 mo., 1 day
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 43 yrs., 1 month, 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....
City or town..... Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No..... ?
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

William Edward Chambers

3. (b) Social Security Number

none

4. Sex..... male 5. Color or race..... white 6. (a) Single, married, widowed, or divorced..... single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)..... April 24, 1867

8. AGE: Years..... 79 Months..... 9 Days..... 26 If less than one day..... hrs. min.

9. Birthplace..... Maryland
(Town, county, and state)

10. Usual occupation..... Detective

11. Industry or business..... Detective

12. Name..... ? Chambers

13. Birthplace..... ?

14. Maiden name..... ?

15. Birthplace..... ?

16. Informant..... Hospital records

Address..... Catonsville-28, Maryland

17. Burial, cremation, or removal (Which?)..... Burial Date thereof..... 2/21/47
(month) (day) (year)

Cemetery or crematory..... Mt. Clear

Location..... Catonsville

18. Funeral director..... William J. Fox

Address..... 12144 Fort St.

19. 2-20-47 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

2B. DATE OF DEATH..... February 19 1947 2:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 18 1947 to February 19 1947 and that I last saw him alive on February 19 1947

Immediate cause of death..... Chronic myocardial insufficiency 9 months

Due to..... Chronic arteriosclerotic cardiovascular disease Indefinite

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results..... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Isadore Tuerk, M.D.

M. D. or other

Address..... Catonsville-28, Md. Date signed 2-20-47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01356

Reg. Dist. No. 300

1. PLACE OF DEATH:

County Balto.
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

2205 Rockwell Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2205 Rockwell Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

MARY E. CLEMENTS

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife Walter L. Clements

7. Birth date of deceased (mo., day, yr.) Jun 3 10, 1876 6.(c) If alive, give age years

8. AGE: Years 70 Months 7 Days 23 If less than one day hrs. min.

9. Birthplace Oella, Md.
(Town, county, and estate)

10. Usual occupation Housewife

11. Industry or business

12. Name William Sweet
13. Birthplace England

14. Maiden name Virginia Ann Day
15. Birthplace Md.

16. Informant Mr. Carroll W. Clements
Address 2205 Rockwell Ave.

17. Burial Date thereof 2/5/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Lorraine Cem.Location Woodlawn, M₁.18. Funeral director WM. J. TICKNER & SONSAddress Balto., Md

19. 2-4 x 7 19. Doc [Signature]
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3, 19 47 at 1:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 20, 1945 to Feb. 3, 1947,
and that I last saw him er. alive on Jan. 8, 1947.

Immediate cause of death

A deno-Carcinoma of the
Right Breast.....

DURATION

2. yrs

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE.....

M. D. or other

Address Catonsville, Md Date signed 2-3-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

01357

Reg. Dist. No. 282-301

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 16 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Mary's
 City or town Leonardtown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

W. Dawkins Clements

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Sarah Vallandingham
 6.(c) If alive, give age 55 years
 7. Birth date of deceased (mo., day, yr.) January 22, 1887
 8. AGE: Years 60 Months - Days 10 If less than one day _____ hrs. _____ min.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1 19 47 at 8:20 P.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 16 19 47 to February 1 19 47
 and that I last saw him in alive on February 1 19 47
 Immediate cause of death acute myocardial failure DURATION 10 hrs.

Due to Chronic hypertensive C-V-R disease Indef.

Due to _____

Other conditions Osteomyelitis right thigh (old) Indef.
 (Include pregnancy within 8 months of death)

Major findings of operations _____

Autopsy results none Date of op. _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

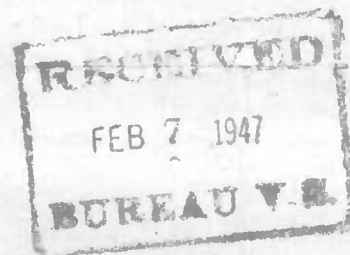
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury Stroke Injured at work? _____23. SIGNATURE Isadore Tuerk, M.D. M. D. or other _____

Catonsville-28, Maryland 2-3-47
 Address _____ Date signed _____

9. Birthplace Leonardtown, Maryland
 (Town, county, and state)
 10. Usual occupation Painter
 11. Industry or business Painting
 12. Name John Clements
 13. Birthplace Leonardtown, Maryland
 14. Maiden name Rose Jarboe
 15. Birthplace Leonardtown, Maryland
 16. Informant Hospital records
 Address Catonsville-28, Maryland
 17. Burial Date thereof Feb 5-1947
 (Burial, cremation, or removal Which?) (month) (day) (year)
 Cemetery or crematory St. Aloysius Cemetery
 Location Leonardtown Md
 18. Funeral director W. C. Mattingley Sons
 Address Leonardtown Md
 19. 2/4 19 47 Clement
 (Date rec'd by registrar) Registrar



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age is shown on
4-109 2/27/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01358

Reg. Dist. No. 190

1. PLACE OF DEATH:

County BaltimoreCity or town Relay, 27, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? April 8, 1905Hospital, institution, or street address where death occurred:
Relay SanitariumHow long in hospital or institution? April 8, 1905

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residences of mother)

State Md. County BaltimoreCity or town Relay
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)
2.(a) If veteran, name war Spanish American

3.(a) FULL NAME

Richard Colton

3.(b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife _____

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Apr. 1, 18818. AGE: Years 26 Months 6 Days 5 If less than one day _____ hrs. _____ min.9. Birthplace Allensfresh, Charles Co., Md.
(Town, county, and state)10. Usual occupation Veteran

11. Industry or business

12. Name John Colton13. Birthplace Maryland14. Maiden name Virginia Dutton15. Birthplace Maryland16. Informant Mrs. E.G. FlesterAddress 4708 Butterworth Place, Washington,17. Burial Date thereof Feb 8th 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Arlington Nat. Cem.Location Arlington, Virginia18. Funeral director S. H. X. X. Co.Address 2901 - 14th St. N.W. Wash., D.C.19. Feb 5 47 (Date rec'd by Registrar) 19. (Miss) E. Bird Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5th 1947 at 10:45 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1st 1931 to Feb 5th 1947 and that I last saw him alive on Feb 5th 1947Immediate cause of death Cerebral thrombosis DURATION 8 daysDue to Hypertension heart disease SwampDue to Swamp

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE James P. Gandy M. D. or otherAddress Relay 22, Md. Date signed Feb 5 47

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FEB 8 1947

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlea St., Baltimore 134

CERTIFICATE OF DEATH BC

Reg. Diat. No. 01359 321

1. PLACE OF DEATH:
County... Baltimore
City or town... Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 0 yrs. 0 mos., 3 days
Hospital, institution, or street address where death occurred Mt. Wilson Branch, Md. Tuberculosis Sanatorium
How long in hospital or institution? 0 yrs., 0 mos., 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State... Maryland County...
City or town... Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2735 Cylburn Ave., Balto., Md.
(If rural, give LOCATION)
2.(a) If veteran, name war... ☒

3. (a) FULL NAME
George Vincent Considine

3. (b) Social Security Number
218-03-5374

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widower

6. (b) Name of husband or wife Susan Considine

6. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) January 16, 1895

8. AGE: Years 52 Months 1 Days 5 If less than one day
..... hrs. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation... Salesman

11. Industry or business

FATHER 12. Name James F. Considine

13. Birthplace Baltimore, Maryland

MOTHER 14. Maiden name Annie F. Kelly

15. Birthplace Baltimore, Maryland

16. Informant Joseph L. Considine, Brother

Address 2735 Cylburn Ave., Balto., Md.

17. Burial Date thereof Feb. 24, 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetary or crematory Cathedral Cemetery

Location 4300 Old Frederick Rd., Balto., Md.

18. Funeral director Chas. F. Evans & Sons

Address 118 W. Mt. Royal Ave., Balto., Md.

19. Feb. 21, 1947 Earl T. Webster

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 21, 1947 12:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 18, 1947 to Feb. 21, 1947 and that I last saw him alive on February 21, 1947

Immediate cause of death Pulmonary Tuberculosis DURATION 5 yrs.

Due to Tubercle Bacilli

Due to

Other conditions Tuberculous Laryngitis 6 Mos.

(Include pregnancy within 3 months of death)

Major findings of operations No operation

Date of op.

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

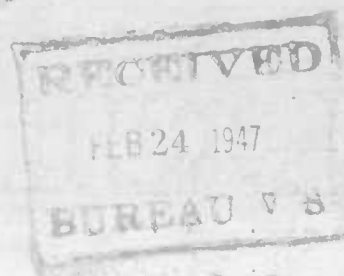
33. SIGNATURE B. J. Siegel M.D. M. D. or other

Address Mount Wilson, Maryland Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-25

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (950)

CERTIFICATE OF DEATH

Reg. Dist. No. 38

01360

1. PLACE OF DEATH:

County Baltimore
City or town Stonelaigh (Balto. 12)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
City or town Stonelaigh
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7115 Buxton Rd. Balto. 12
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Lawrence E. Crowther

3. (b) Social Security Number

4. Sex F. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Joseph M. Crowther

7. Birth date of deceased (mo., day, yr.) June 6, 1867 6. (c) If alive, give age _____ years

8. AGE: Years 79 Months 8 Days 22 If less than one day _____ hrs. _____ min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)

10. Usual occupation Homemaker

11. Industry or business

FATHER 12. Name John R. Parker

13. Birthplace Balto. Co. Md.

MOTHER 14. Maiden name Calgate Charlles Shipley

15. Birthplace Balto. Co. Md.

16. Informant Mrs. C. G. Warner

Address 7115 Buxton Rd Balto. 12

17. Burial Date thereof Mar. 2, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Graves

Location Sparks, Md.

18. Funeral director Sandon M. Brooks

Address Sparks, Md.

19. March 1 19 47 Deputy Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 28 19 47 at 7:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JAN 5 19 47 to Feb 28 19 47

and that I last saw H.E.R. alive on Feb 28 19 47

Immediate cause of death Cardiac failure

(Decompensative)

Auricular fibrillation

Due to Hypertension

Due to Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lawrence C. Post M.D. M. D. or other

Address 6805 York Road Date signed 2/28/47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 29 1947
BUREAU OF

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2-380-2-10

PLEASE WRITE MAINLY, WITH UNFADING INK. Supply every item of information accurately. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-2

CERTIFICATE OF DEATH

★ 01361

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 years, 9 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 4 years, 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 709 Light Street
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Arthur Cummings

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed
 6. (b) Name of husband or wife ?
 7. Birth date of deceased (mo., day, yr.) April 24, 1879
 8. AGE: Years 67 Months 10 Days 4 If less than one day _____ hrs. _____ min.

5. Birthplace Tilghmans Island, Md.
 (Town, county, and state)
 10. Usual occupation Carpenter
 11. Industry or business Carpentry
 12. Name John Cummings
 13. Birthplace Maryland
 14. Maiden name Susie Brownell
 15. Birthplace Maryland

16. Informant Hospital records
 Address Catonsville-28, Maryland
 17. Burial Date thereof 3-27-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Spring Grove State Hospital
 Location Catonsville 28, Maryland
 18. Funeral director Spring Grove State Hospital
 Address Catonsville 28, Maryland

19. 3-27-47 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 28 19 47, at _____ M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 19 19 44, to February 28 19 47
 and that I last saw him alive on February 28 19 47

Immediate cause of death Sclerotic coronary disease DURATION indef.
 Due to Pulmonary edema, extensive 2 hrs.
 Due to Broncho pneumonia 2 days
 Other conditions Diffuse advanced glomerular nephritis indefinite
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results as above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE Isadore Tuerk, M.D. M. D. or other _____
Catonsville-28, Md. Address _____ Date signed 2-28-47

RECEIVED

MAR 31 1947

BUREAU V B.

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH:

County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Hood Nursing Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltimoreCity or town Lanadowne
(If outside city or town limits, write RURAL and give nearest town)Street No. 237 3rd Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Johanna W Dougherty

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Late Avery Dougherty

6.(c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

1862

8. AGE:

Years

Months

Days

If less than one day

? 85

hrs. min.

9. Birthplace

Germany

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19. 2-20

(Date rec'd by registrar)

20. 4721. Harsh22. Miller23. Register24. 2-1925. 2-1926. 2-1927. 2-1928. 2-1929. 2-1930. 2-1931. 2-1932. 2-1933. 2-1934. 2-1935. 2-1936. 2-1937. 2-1938. 2-1939. 2-1940. 2-1941. 2-1942. 2-1943. 2-1944. 2-1945. 2-1946. 2-1947. 2-1948. 2-1949. 2-1950. 2-1951. 2-1952. 2-1953. 2-1954. 2-1955. 2-1956. 2-1957. 2-1958. 2-1959. 2-1960. 2-1961. 2-1962. 2-1963. 2-1964. 2-1965. 2-1966. 2-1967. 2-1968. 2-1969. 2-1970. 2-1971. 2-1972. 2-1973. 2-1974. 2-1975. 2-1976. 2-1977. 2-1978. 2-1979. 2-1980. 2-1981. 2-1982. 2-1983. 2-1984. 2-1985. 2-1986. 2-1987. 2-1988. 2-1989. 2-1990. 2-1991. 2-1992. 2-1993. 2-1994. 2-1995. 2-1996. 2-1997. 2-1998. 2-1999. 2-19100. 2-19

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18 19 47 at 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 11 19 47 to Feb 18 19 47and that I last saw him alive on Feb 18 19 47

Immediate cause of death

Chr Myocarditis

DURATION

1 mon

Due to

Secondary Quasemia

Due to

P.A. of Colon

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

James H. Miller M. D. or otherAddress Baltimore Date signed 2-19

RECEIVED
FEB 22 1947
BUREAU V. S.

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9370

CERTIFICATE OF DEATH

Reg. Dist. No. 01333

1. PLACE OF DEATH:

County Baltimore
 City or town Catonville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Up to home
 Hospital, institution, or street address where death occurred:
Edmon Hallister Nursing Home
 How long in hospital or institution? 2-17-47

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Baltimore
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1527 E 35th St
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3. (a) FULL NAME

Charles W Davis

3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife 1860?
 7. Birth date of deceased (mo., day, yr.) 1860?

8. AGE: Years 87? Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace New York
 (Town, county, and state)

10. Usual occupation Home

11. Industry or business _____

12. Name Charles W Davis

13. Birthplace NY

14. Maiden name May E. Mackell

15. Birthplace Pa

16. Informant Mrs Ida C Lambert

Address 1527 E 35th St

17. Cremation Date thereof 2-17-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Falmarnock, Pa

Location Surge & Farley

18. Funeral director Cornwall, Md

Address 2-17-47

19. 2-17-47 19. 47 Harriet M. Miller
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17 19. 47 at 3:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 6 19. 46 to Feb 17 19. 47
 and that I last saw him alive on Feb 16 19. 47

Immediate cause of death Cor Myocarditis DURATION 1 mon

Due to Dr. F. C. Felerova

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

Signature Reese Howard

Address Belour Beece Date signed 2/17

RECEIVED
FEB 18 1947
BUREAU V.A.

1-35

Evidence for the change of
age and birthdate is shown
on G 108 2/24/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

01364
Reg. Dist. No. 301

1. PLACE OF DEATH:

County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 14 days
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 2 months, 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George
City or town Rosaryville, Cheltenham, P. O.
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2. (a) If veteran, name war _____

3. (a) FULL NAME

Marcellus Dean

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
6. (b) Name of husband or wife Margaret Burch
6. (c) If alive, give age 72 years
7. Birth date of deceased (mo., day, yr.) November 12, 1870 1876
8. AGE: Years 70 Months 76 Days 2 If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business Farm
12. Name William Dean
13. Birthplace Maryland
14. Maiden name Sarah ?
15. Birthplace Maryland

16. Informant Hospital records
Address Catonsville-28, Maryland
17. Burial Date thereof 2-12-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory _____
Location Fort Lincoln M. S.
18. Funeral director W. W. Chambers
Address Washington D. C.
19. 2-11 47 Harold Miller
(Date rec'd by registrar) (year) (month) (day) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9 19 47 at 4:10 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
November 22 1946 to February 9 1947
and that I last saw him alive on February 9 1947

Immediate cause of death Left upper lobar pneumonia,
etiology undetermined

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings of operations _____
Date of op. _____
Autopsy results as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury Isadore Turk, M.D. Injured at work? _____
23. SIGNATURE Isadore Turk, M.D. M. D. or other _____
Address Catonsville-28, Md. Date signed 2-10-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 13 1947

RECEIVED

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(109)

01365

CERTIFICATE OF DEATH

Reg. Dist. No. 330

1. PLACE OF DEATH:

County Baltimore
 City or town Owings Mills
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 month 6 days
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Owings Mills
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Reisterstown Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Donald Lee Diehl

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Jan. 12, 1947 6.(c) If alive, give age years

8. AGE: Years 1 Months 6 Days 6 If less than one day hrs. min.

9. Birthplace Owings Mills, Balto., Md.
 (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name not married

13. Birthplace

MOTHER 14. Maiden name Elsie Virginia Diehl

15. Birthplace Owings Mills, Md.16. Informant Mr. John A. DiehlAddress Owings Mills

17. Burial Date thereof Feb. 20, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Reisterstown MethodistLocation Reisterstown, Md.18. Funeral director Wm. Berryman & SonsAddress Reisterstown, Md.

19. 2-19- 19 47 Mary B F Line
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 18 19 47 at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-18-47 19 47 to 2-18-47 19

and that I last saw him alive on not seen alive 19

Immediate cause of death

DURATION

Pneumonia, bronch. su. & so. 10 days

Due to

Due to

Other conditions

(Including pregnancy within 3 months of death)

Major findings of operations

NONE

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? NONE
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE D. D. Caples M. D.
 M. D. or other

Address Reisterstown, Md. Date signed 2-18-47

CERTIFICATE OF DEATH

DECEASED (Full Name)

DATE OF DEATH

AGE (Years)

SEX

PLACE OF BIRTH

DATE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

POST-MORTEM EXAMINATION

Remarks

RECEIVED
FEB 21 1947
B. P. L. J. V. B.

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01366 381

1. PLACE OF DEATH:

County Baltimore
 City or town Rodgers Forge
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 weeks
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County Baltimore
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4223 Fernhill Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Emma C Draper

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow6. (b) Name of husband or wife Walter Draper7. Birth date of deceased (mo., day, yr.) 8/6/53 6. (c) If alive, give age _____ years8. AGE: Years 83 Months 6 Days 1 It less than one day _____ hrs. _____ min.9. Birthplace Long Island N.Y.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Stallman13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant Valerie SpencerAddress 417 Regester Ave17. Burial Date thereof July 17/1947
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory GreenfieldLocation Hempstead Long Island N.Y.18. Funeral director Wm. J. AndersonAddress 4204 Ridgewood Ave19. Feb. 15 19 47 A. W. Hedrick
(Date rec'd by registrar) Registrar aed

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 13 19 47 at 5:20 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 12 19 47 to Feb 13 19 47 and that I last saw h. & R. alive on Feb 13 19 47

Immediate cause of death _____ DURATION _____

Hypertensive Cardio Vascular Disease - Cerebral HemorrhageDue to Hypertension

Due to _____

Other conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Laurence C. Fosh M.D. M. D. or other _____Address 6805 York Rd Date signed 2/13/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Benson
1 West Overlea Ave.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (732)

CERTIFICATE OF DEATH

Reg. Dist. No. 430

01367 8

1. PLACE OF DEATH:

County Overlea
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:
1 Ellmont Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Overlea
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. # 1 Ellmont Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Joseph W. Emge

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife Anna Emge

7. Birth date of deceased (mo., day, yr.) Jan. 26, 1863 6. (c) If alive, give age _____ years

8. AGE: Years 84 Months -- Days 30 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name John Emge

13. Birthplace Md.

14. Maiden name ? Harris

15. Birthplace Md.

16. Informant Mrs. Leona Geyer

Address 2810 Berwick Avenue, 14

17. Burial Date thereof 2/28/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Baltimore

Location Baltimore

19. Funeral director Leonard J. Ruck

Address 5305 Harford Road-14-

19. 2/27 47 SW Hedrick
(Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25th, 1947 at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 21 1947 to February 25 1947 and that I last saw him alive on February 25 1947

Immediate cause of death Cerebral Hemorrhage DURATION 2 days

Due to Cardio Vascular Hypertensive Disease 15 years

Due to Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Michael J. Dausch M.D. M. D. or other

Address 1 W. Overlea Ave. Date signed 2/25/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01368 420

1. PLACE OF DEATH:

County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 1811 Summit Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Caroline

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

83-816hrs.min.

9. Birthplace

Baltimore, Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

16. Funeral director

Address

19.

(Date rec'd by registrar)

19

47G. W. Hedrick

Registrar

3. (b) Social Security Number

212-16-3751a

MEDICAL CERTIFICATION

20. DATE OF DEATH

February 27, 1947 at 8:40 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 39 to Feb. 27, 1947and that I last saw him alive on Feb. 27, 1947

Immediate cause of death

Chronic Myocarditis

DURATION

34

Due to

arterio-sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed 3/3/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 300

1. PLACE OF DEATH:

County Baltimore

City or town Catonsville 28
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 days

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 1302 W. Lexington St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Jennie Farrell

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

female white single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 1873 6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day
74 ? ? hrs. min.9. Birthplace Maryland
(Town, county and state)

10. Usual occupation house work

11. Industry or business at home

12. Name James Farrell

13. Birthplace Fitzgerald

14. Maiden name Fitzgerald

15. Birthplace

16. Informant Hospital Records

Address Catonsville 28, Md.

17. Burial, cremation, or removal, Which? 3/1/47
(Date thereof) (month) (day) (year)

Cemetery or crematory Bow Cathedral

Location 4300 Old Federal Road

18. Funeral director John L. Brown & Son

Address 904 - 27 Hollins St.

19. 2/26 47 D.W. Redick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 24, 1947 at 4:25 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
January 29, 1947 to February 24, 1947
and that I last saw him alive on February 24, 1947

Immediate cause of death Acute cardiac failure DURATION minutes

Due to Chronic cardiovascular-renal disease indefinitely

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Isadore Turk, M.D.

Isadore Turk, M. D. M. D. or other
Address Catonsville 28, Md. Date signed 2/25/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C1370

Reg. Dist. No.

381

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Armcoast Nursing Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.

4130 Roland Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

ALMA MAY FETZER

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Widow

6. (b) Name of husband or wife Ernest M. Fetzer

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

Jan. 1, 1886

8. AGE:

Years

Months

Days

If less than one day

61

1

4

hrs. min.

9. Birthplace Ohio

(Town, county, and state)

10. Usual occupation Inspector - retired

11. Industry or business Barefoot Sole Co.

12. Name Harvey Heller

13. Birthplace Ohio

14. Maiden name Hannah Iden

15. Birthplace Ohio

16. Informant Mrs. Edith Tetlock

Address 4130 Roland Ave.

17. Burial Date thereof 2/7/47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Druid Ridge Cem.
Pikesville, Md.

Location

18. Funeral director WM. J. TICKNER & SONS

Address Balto., Md.

19. 2/7/47 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5, 1947 at 8:00 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 29, 1946 to Feb. 4, 1947

and that I last saw her alive on Feb. 4, 1947

Immediate cause of death Carcinoma of
cervix uteri

DURATION

10 years

Due to

Due to

Other conditions Pyelitis chronic

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

C. Bernard Brack M.D.

M. D. or other

Address

11 E. Chase St.

Date signed

Feb. 6, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 01371 8
200

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 2 years, 1 month, 22 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution?..... 2 years, 1 month, 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....
 City or town..... Baltimore-29
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 126 South Hilton Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... ✓

3. (a) FULL NAME

Adolph Feuerherd

3. (b) Social Security Number

215-14-5597.

4. Sex..... male 5. Color or race..... white 6.(a) Single, married, widowed, or divorced..... married
 6.(b) Name of husband or wife..... Catherine Grady
 6.(c) If alive, give age..... 52 years
 7. Birth date of deceased (mo., day, yr.)..... January 29, 1868
 8. AGE: Years..... 79 Months..... - Days..... 27 If less than one day..... hrs. min.

9. Birthplace..... Baltimore, Maryland
 (Town, county, and state)
 10. Usual occupation..... Contractor
 11. Industry or business..... Stonemasonry
 12. Name..... Frederick Feuerherd
 13. Birthplace..... Germany
 14. Maiden name..... Fredericka Betschia
 15. Birthplace..... Germany

16. Informant..... Hospital records
 Address..... Catonsville-28, Maryland
 17. Burial Date thereof..... Feb. 27-47.
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory..... Loudon Park Cemetery
 Location..... Baltimore - Md.
 18. Funeral director..... Charles J. Schwab
 Address..... 3572 Frederick Ave.
 19. 2/26 47 Dr. Medical
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... February 25 19.. 47 at 12:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
January 3 19.. 45 to February 25 19.. 47
 and that I last saw him alive on February 25 19.. 47

Immediate cause of death..... Myocardial insufficiency DURATION..... 2 months

Due to..... Arteriosclerotic cardiovascular-renal disease Indefinite

Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.

Autopsy results..... none
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE..... Henry C. A. Mead M.D.
Henry C. A. Mead, M.D. M. D. or other
 Address..... Catonsville-28, Md. Date signed..... 2-25-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 380

1. PLACE OF DEATH:

County Baltimore

City or town Annerlea
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
101 Murdock Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Annerlea
(If outside city or town limits, write RURAL and give nearest town)

Street No. 101 Murdock Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Lyda T. Foster

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife George H. Foster

7. Birth date of deceased (mo., day, yr.) May 19 - 1868 6.(c) If alive, give age years

8. AGE: Years 78 Months 9 Days 9 If less than one day hrs. min.

9. Birthplace Ohio
(Town, county, and state)

10. Usual occupation

11. Industry or business Housewife

12. Name L. V. B. Taylor

13. Birthplace Ohio

14. Maiden name Amelia Blue

15. Birthplace Ohio

16. Informant George H. Foster

Address 101 Murdock Road

17. Burial Date thereof 2/26/47
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Brosnick Hill

Location Toddman Md.

18. Funeral director John C. Moran

Address 3000 E Baltimore St

19. 2/25 19 47 A.W. Hedner
(Date rec'd by registrar) Dr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/23 19 47, at 6:34 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/1 19 46, to 2/23 19 47

and that I last saw him alive on 2/20 19 47

Immediate cause of death Cerebral thrombosis DURATION 1 Hr.

Due to Cardio-vascular

Due to renal disease 10 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles F. O'Donnell M. D. or other

Address 7301 York Rd Date signed 2/23/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-0

01374

CERTIFICATE OF DEATH

Reg. Dist. No. 57

1. PLACE OF DEATH:

County BaltimoreCity or town Texas
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Texas, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. Texas Lane
(If rural, give LOCATION)

2(a) If veteran, name war

No

3. (a) FULL NAME

James S. Freeland

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Ida May (nee Badders)

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct. 5, 1886

8. AGE:

Years

Months

Days

If less than one day

60412

hrs.

min.

9. Birthplace

Harford Co., Md.
(Town, county, and state)

10. Usual occupation

P. P. Truck Foreman

11. Industry or business

Penna. P. R.

MOTHER FATHER

12. Name

Levi Freeland

13. Birthplace

Harford Co. Md.

14. Maiden name

Lida Lambert

15. Birthplace

Maryland

16. Informant

Mr. J. S. Freeland

Address

Texas, Md.

17.

(Burial, cremation, or removal, Which?)

Date thereof

Feb. 20, 1947
(month) (day) (year)

Cemetery or crematory

Sparks

Location

Sparks, Md.

18. Funeral director

Landen M. Brink

Address

Sparks, Md.

19.

Feb. 17, 1947
(Date rec'd by registrar)Wilmer C. Ensor

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17, 1947 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 15, 1942 to Feb. 17, 1947

and that I last saw him alive on

Feb. 17, 1947

Immediate cause of death

Coronary thrombosis
(3rd attack)

DURATION

2 hrs.

Due to

myocarditis5 yrs.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Wilmer C. Ensor M.D.

M. D. or other

Address

Cockeysville Md.Date signed 2/17/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 20 1947

RECEIVED

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death cleanly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-2

CERTIFICATE OF DEATH

01373

MV 370
Reg. Dist. No.

1. PLACE OF DEATH:

County BaltimoreCity or town Cockeysville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Jonas Freeman

4. Sex

M

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Bessie Lee (nee Johnson)6. (c) If alive, give age 28 years7. Birth date of deceased (mo., day, yr.) Dec. 22, 1898

8. AGE:

Years

48

Months

1

Days

28

If less than one day

hrs.

min.

9. Birthplace North Carolina

(Town, county, and state)

10. Usual occupation General Laborer

11. Industry or business

FATHER

12. Name

Polie Freeman

13. Birthplace

North Carolina

MOTHER

14. Maiden name

Mary A. Ward

15. Birthplace

North Carolina16. Informant Mrs. Jonas Freeman

Address

Cockeysville, Md17. Burial Date thereof Feb. 23, 1947

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory

Balton

Location

Balton, Columbus 6 North Carolina18. Funeral director Samson M. Brooks

Address

Sparks, Md19. 2-21-47 Wilmer C. Engor

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County BaltimoreCity or town Cockeysville (Rural)
(If outside city or town limits, write RURAL and give nearest town)Street No. York Rd
(If rural, give LOCATION)2. (a) If veteran, name war ☒

3. (b) Social Security Number

246-10-9600

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 1947, at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

None 1947 to 1947and that I last saw h. None alive on 1947

Immediate cause of death

Crushed skull - carbon
Fall from truck by unsafely
riding with saw over head

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Auto Date of 2/19/47Where did injury occur? Cockeysville Balto Md
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) DrivewayMeans of Injury Fell from truck Injured at work? Yes23. SIGNATURE Rollin L. Hudson MD D.M.E.

M. D. or other

Address Towson 4 Md Date signed 2/19/47

RECEIVED

FEB 26 1947

BUREAU V 8

2-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The longer the age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4)

CERTIFICATE OF DEATH

Reg. Dist. No. 300

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Over five years
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 4 years 7 months 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Catonsville (28)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 18 Nunnery Lane
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Annie Gardner

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow
 6. (b) Name of husband or wife Edward Henry Gardner
 6. (c) If alive, give age D @ 71 years
 7. Birth date of deceased (mo., day, yr.) February 8, 1871
 8. AGE: Years 76 Months 0 Days 10 If less than one day
 hrs. min.

9. Birthplace Baltimore, Md.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Home
 12. Name John Tottle
 13. Birthplace England
 14. Maiden name Sophia Colbert
 15. Birthplace Maryland

16. Informant Hospital Records
 Address Catonsville, 28, Md.
 17. Burial Date thereof 2/22/47
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Loudon Park
 Location Baltimore, Md.
 18. Funeral director George W. Little
 Address 2700 Edmondson Ave.

19. 2-20 47 Accepted
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 18, 1947 19..... at 5:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
July 7 1942 19..... to February 18, 1947
 and that I last saw her alive on February 18 1947 19.....

Immediate cause of death Coronary occlusion

DURATION

20 hrs.Due to Chronic hypertensive C-V-R disease

Indef

Due to
 Other conditions Diabetes Mellitus
 (Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.

Autopsy results None held
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Henry C. A. Mead, M.D.
Henry C. A. Mead, M.D. M. D. or other
 Address Catonsville, 28, Md. Date signed 2/18/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4-0)

CERTIFICATE OF DEATH

01376

Reg. Dist. No. 350

1. PLACE OF DEATH:

County BaltimoreCity or town Glyndon
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Cockeysville (Rural)
(If outside city or town limits, write RURAL and give nearest town)Street No. Falls Rd
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William F. Garthling

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Elizabeth (nee Song)6. (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.)

Aug 9, 1895

8. AGE:

Years

51

Months

6

Days

18

If less than one day

hrs.

min.

9. Birthplace

Balto Co. Md.
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER
MOTHER

12. Name

Frank Garthling

13. Birthplace

Balto. Co. Md.

14. Maiden name

Sophia Wittkopf

15. Birthplace

Detroit Michigan

16. Informant

Mrs. Wm. F. Garthling

Address

Glyndon, Balto. Co., Md.

17.

(Burial, cremation, or removal. Which?)

Burial

Date thereof

(month) (day) (year)

Cemetery or crematory

Grace Methodist

Location

Lestrum Ridge Balto. Co. Md.

18. Funeral director

Landrum M. Brooks

Address

Sparks Md.

19.

(Date rec'd by registrar)

Feb. 27, 47Mary B. Elmer

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/27/47 1947 at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1/1/47 1947 to 2/27/47 1947and that I last saw him/her alive on 2/27/47 1947

Immediate cause of death

Carcinoma of esophagus

DURATION

1 yr

Due to

Due to

Other conditions

metastases to liver

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. H. Saffell

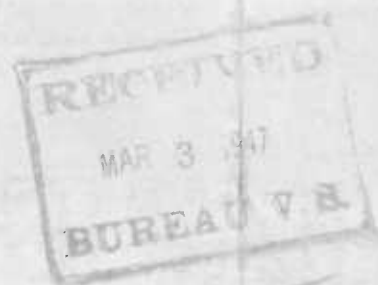
M. D. or other

Address

Baltimore Md.

Date signed

2/27/47



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

01378 301
Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore
City or town Catonsville Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 212 Shady York Court
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Rachel Waters German

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Widow

6. (b) Name of husband or wife Chas. V. W. German

7. Birth date of deceased (mo., day, yr.) Jan. 17, 1877 6. (c) If alive, give age years

8. AGE: Years 70 Months 1 Days 9 If less than one day hrs. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual occupation at home

11. Industry or business

12. Name Richard L. Waters

13. Birthplace Md.

14. Maiden name Rennie Hobbs

15. Birthplace Md.

16. Informant Elmer R. Feldman

Address 2925 Walbrook Ave Balto 16 Md.

17. Burial Date thereof 2-29-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Good Shepherd

Location Elmhurst City Md.

18. Funeral director F. P. Nigumbatham

Address Elmhurst City Md.

19. 2-28 1947 Harriet Miller
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 26 1947 at 10:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 11 1942 to Feb. 26 1947

and that I last saw him alive on February 26 1947

Immediate cause of death Myocardial Insufficiency

Due to Chr. Cor. Vase - Renal Disease

Other conditions Diabetes Mellitus

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William K. Gallagher M.D.

Address Catonsville 28, Md. Date signed 2/27/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 1 1917
BUREAU V.B.

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. For correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *04379* *RC* *XX*

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Fort Howard, MarylandHow long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 216 E. Pratt Street
(If rural, give LOCATION)2(a) If veteran, name war VW-2

3. (a) FULL NAME

HENRY CABLE GIBSON

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MaleWhiteSingle

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-28-988. AGE: Years Months Days If less than one day
48 2 17 hrs. min.9. Birthplace Scottsburg, Va.

(Town, county, and state)

10. Usual occupation Railroad work.

11. Industry or business

12. Name Thomas G. Gibson13. Birthplace Pittsylvania Co. Va.14. Maiden name Ellen E. Pierce15. Birthplace Pittsylvania, Va.16. Informant Clinical Records, Vets. Adm. Hosp.
Address Fort Howard, Maryland17. Burial Date thereof Feb 18-1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore NationalLocation Frederick Avenue, Baltimore, Md.18. Funeral director Ellsworth ArmacostAddress Baltimore, Maryland 3911 Liberty Heights Ave19. 2/17 47 A.W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 15, 19 47, at 2:45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 13, 19 47, to February 15, 19 47and that I last saw him alive on 19

Immediate cause of death

PNEUMOCOCCIC MENINGITIS

DURATION

2 daysplusDue to PNEUMOCOCCIC SEPTICEMIADue to PNEUMOCOCCAL PNEUMONIA

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury

Injured at work?

23. SIGNATURE Kenneth J. Taber
KENNETH TABER, M.D.

M. D. or other

Address FORT HOWARD, MARYLAND Date signed 2/15/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (474)

CERTIFICATE OF DEATH

01380

Reg. Dist. No. 33

1. PLACE OF DEATH:

County BaltoCity or town Hyppus
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County BaltoCity or town Hyppus
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Ira S. Gill

3. (b) Social Security Number

292-10-4511

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Jennie P. Gill

7. Birth date of deceased (mo., day, yr.)

Jan. 31 1881

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

665

hrs.

min.

9. Birthplace

Balto co.

(Town, county, and state)

10. Usual occupation

Bus Operator

11. Industry or business

FATHER

12. Name

George R. Gill

13. Birthplace

Balto co.

MOTHER

14. Maiden name

Mollie Sparks

15. Birthplace

Balto co.

16. Informant

Address

Marshall GillHyppus md.

17.

(Burial, cremation, or removal, Which?)

Date thereof

Feb. 7/46
(month) (day) (year)

Cemetery or crematory

St. Paul

Location

Balto. co.

18. Funeral director

Address

J.F. Eline - SonsRuatastown md.

19.

(Date rec'd by registrar)

19

47Mary B. E. Line

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5 19 47 at 3 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 18 19 46 to February 5 19 47and that I last saw him alive on February 1 19 47

Immediate cause of death

Carcinoma Lung

DURATION

?

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Edgar W. Bush MD

M. D. or other

Address

Hampstead MdDate signed 2-5-47

RECEIVED

FEB 10 1947

BUREAU V 8

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 470

1. PLACE OF DEATH:

County Baltimore
 City or town Chesaco Park
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 15 yrs.
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Baltimore
 City or town Chesaco Park
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 7928 Bridge Ave.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Emma Gittings

3. (b) Social Security Number

none

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) January 14, -1868
 6. (c) If alive, give age _____ years

8. AGE: 79 Years 1 Months 14 Days If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Md.
 (Town, county, and state)

10. Usual occupation

House work, -

11. Industry or business

John J. Gittings

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant Mrs. John WaltersAddress 7928 Bridge Ave.17. Burial Date thereof March 3-47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Parkwood Cemetery

Location

18. Funeral director Charles J. SchwalbAddress 3512 Frederick Ave.19. 3-3 47 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

2D. DATE OF DEATH Feb 28 19 47 at 8:45 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 47 to Feb 28 19 47and that I last saw him/her alive on Feb 28 19 47

Immediate cause of death

Coronary Thrombosis

DURATION

SuddenDue to Arterio Sclerotic - Cerebrovascular disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Yes M. Baumgardner M. D. or otherAddress Balto 6 Md Date signed 2-28-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

Reg. Dist. No. 01382 570

1. PLACE OF DEATH:

County Baltimore
City or town Cockeysville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Padonia Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
City or town Cockeysville
(If outside city or town limits, write RURAL and give nearest town)

Street No. Padonia Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Charles Henry Gladfelter

3. (b) Social Security Number

1111

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
-----------------------	----------------------------------	--

6. (b) Name of husband or wife Elizabeth Talbott Gladfelter

7. Birth date of deceased (mo., day, yr.) March 1, 1866 1866

8. AGE:	Years	Months	Days	If less than one day
<u>80</u>	<u>11</u>	<u>11</u>	<u>11</u>	<u>hrs.</u> <u>min.</u>

9. Birthplace New Market, Penna.
(Town, county, and state)

10. Usual occupation Retired
Shoemaker

11. Industry or business

12. Name David Gladfelter
13. Birthplace Penna.

14. Maiden name Mary Ellen Miller
15. Birthplace Penna.

16. Informant Mrs. Elizabeth T. Gladfelter
Address Padonia Road, Cockeysville, Md.

17. Burial Feb. 15, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Shrewsbury Cemetery

Location Shrewsbury, Penna.

18. Funeral director John Burns' Sons
Address Towson, Maryland

19. 2615 47 Wilmer C. Ensor
(Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 12, 1947 at 9 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15, 1946 to Feb. 12, 1947
and that I last saw him alive on Feb. 12, 1947

Immediate cause of death

Cerebral Hemorrhage
(2nd attack)
Myocarditis

DURATION

3 hrs
5 yrs

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Wilmer C. Ensor M.D. M. D. or other
Address Cockeysville Md Date signed 2/13/47

MARGIN RESERVED FOR BINDING

VS-415

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
19.
FEB ~~X~~ 1947
BUREAU

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coverage is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age is shown on 4-109-2/27/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01383

Reg. Dist. No. 43

1. PLACE OF DEATH:

County Baltimore
City or town Parkville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Sudden
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Daniel Webster Gordon

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Divorced6. (b) Name of husband or wife Goldie Gordon

7. Birth date of deceased (mo., day, yr.) May 18th 1896
6. (c) If alive, give age..... years

8. AGE: Years 50 Months 52 Days..... If less than one day
..... hrs. min.

9. Birthplace Pa.
(Town, county, and state)10. Usual occupation Surg. Mfg. Co.

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant Mrs. Sarah MarcusAddress 751 S Broadway

17. Burial Date thereof 2/12/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Providence Cem.Location Everett Pa.18. Funeral director Wasson Funeral HomeAddress 7401 Belair Rd.

19. Feb. 10 19 47 Mrs. G. L. Ruffin
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Baltimore City

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 715 S. Bond St
(If rural, give LOCATION)

2. (a) If veteran, name war Yes - Army 1919 U.S. ✓

3. (b) Social Security Number

213-16-6585

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 9 19 47 at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

None 19..... to 19.....
and that I last saw him..... alive on 19.....

Immediate cause of death Multiple fractures of body
body, right arm, right arm,
right arm, right arm,
Due to right arm.

Other conditions.....
Due to Auto accident - struck on highway

Other conditions.....
Due to Auto accident - struck on highway

Other conditions.....
Due to Auto accident - struck on highway

Other conditions.....
Due to Auto accident - struck on highway

Other conditions.....
Due to Auto accident - struck on highway

Other conditions.....
Due to Auto accident - struck on highway

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Due to Auto accident - struck on highway

Other conditions.....
Due to Auto accident - struck on highway

Other conditions.....
Due to Auto accident - struck on highway

Other conditions.....
Due to Auto accident - struck on highway

Other conditions.....
Due to Auto accident - struck on highway

Other conditions.....
Due to Auto accident - struck on highway

Other conditions.....
Due to Auto accident - struck on highway

DURATION

2/9/47
(Sudden)

2/9/47

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Auto Date of Feb 9 1947

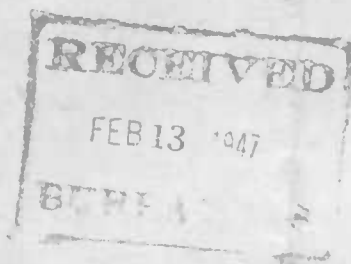
Where did injury occur? Parkville Baltimore Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public highway

Means of injury Struck by auto Injured at work? No

23. SIGNATURE Rollin C. Hudson M.D. D.M.E.

Address..... Date signed.....



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

01384
320

1. PLACE OF DEATH:

County Balto.
City or town Rockdale
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

7718 Liberty Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.
City or town Rockdale
(If outside city or town limits, write RURAL and give nearest town)

Street No. 7718 Liberty Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

ROBERT E. LEE GRIFFITH

3. (b) Social Security Number

none

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

MaleWhiteWidower6.(b) Name of husband or wife Eliza C. Griffith

6.(c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

July 15, 1861

8. AGE:

Years

Months

Days

If less than one day

85623

..... hrs. min.

9. Birthplace Frederick Co., Md.

(Town, county, and state)

10. Usual occupation Salesman11. Industry or business Self12. Name Levins Griffith13. Birthplace Md.14. Maiden name Ruth Warfield15. Birthplace Md.16. Informant Mrs. India Griffith MyersAddress Sykesville, Md.17. Burial Date thereof 2/11/47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Lorraine Cem.Location Woodlawn, Md.18. Funeral director WM. J. TICKNER & SONSAddress Balto., Md.19. 2/10 47 A.W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8, 19 47, at 2:45a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 3 19 47 to Feb 7 19 47and that I last saw him alive on Feb 7 19 47

Immediate cause of death

IschemicMyocardialDue to PneumoniaDue to Generalized arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. Thos. J. Abbott M. D. or otherAddress 4508 Liberty Highway Date signed 2-10-47

RECEIVED
FEB 12 1947
BUREAU V L

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01385

P

Reg. Dist. No. 380

1. PLACE OF DEATH:

County Balto.City or town Parkville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mary C. Griffiths

3. (b) Social Security Number

213-03-5412

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

Brighton G. Griffiths

7. Birth date of

deceased (mo., day, yr.)

May 23-1891

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

65813

hrs.

min.

9. Birthplace

Balto. Md.
(Town, county, and state)

10. Usual occupation

cook.

11. Industry or business

12. Name

Issac Cuddy

13. Birthplace

Balto. Md.

14. Maiden name

Matilda Biscoe

15. Birthplace

St. Mary's Co. Md.

16. Informant

Sadie E. Bristle

Address

2304 Leaberton Heights Ave.

17. Burial, cremation, or removal, Which?

Burial

Date thereof

Feb. 8-47
(month) (day) (year)

Cemetery or crematory

Parkwood Cem.

Location

Taylor Ave.

18. Funeral director

John H. Miller

Address

2334 Jefferson St.

19. 2/7 1947 (Date rec'd by registrar)

19.

Dr. W. H. Hedrick

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Balto.

City or town

Parkville
(If outside city or town limits, write RURAL and give nearest town)

Street No.

3009 Linwood Ave.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 6th.

19

47

at

1:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 19th.45Feb. 6th.47.

and that I last saw h

er

alive on

Feb. 5th.19

Immediate cause of death

Bronchial PneumoniaDURATION
3 days.

Due to

Due to

Other conditions

Cerebral ApoplexyHypertension

(Include pregnancy within 3 months of death)

19 mos.

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

401 E. 25th. St.

M. 2/7/47.

Address

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01386

Reg. Dist. No. 301

1. PLACE OF DEATH:

County Baltimore Co.
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Rev. Opitz Nursing Home

How long in hospital or institution?

18 Mo.2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1106 Rutland Avenue
 (If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

J. PETER HAGELGANS3. (b) Social Security Number
none

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widower6. (b) Name of husband or wife Annie Hagelgans

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

December 19, 1861

8. AGE:

Years

Months

Days

It less than one day

8525

hrs. min.

9. Birthplace

Baltimore, Maryland

(Town, county, and state)

10. Usual occupation

Machinist - retired
Bethlehem Steel Co.

11. Industry or business

FATHER

12. Name

John Hagelgans

13. Birthplace

Germany

MOTHER

14. Maiden name

Unknown

15. Birthplace

n

16. Informant

Mr. Edward Hagelgans

Address

1620 Roundhill Road

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 2-27-47

(month) (day) (year)

Cemetery or crematory

Parkwood Cemetery

Location

Baltimore, Maryland

18. Funeral director

HENRY SANDER & SONS, INC.

Address

NORTH AVE. & BROADWAY

19.

(Date rec'd by registrar)

19.

3/27/47John Hagelgans
DR Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 24 19 47 at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 2 19 46 to Feb 24 19 47
and that I last saw him alive on Feb 24 19 47

Immediate cause of death

Cerebral Hemorrhage

DURATION

1 day

Due to

Arterio Sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01387 300

1. PLACE OF DEATH:

County Dorchester
City or town Edenrovel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 months
Hospital, institution, or street address where death occurred:
Appt. Nursing Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md. County Cecil Co.
City or town Chesic Frederick
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Thomas H. Hagner Jr

3. (b) Social Security Number

4. Sex m 5. Color or race W. 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Nora Atwell

7. Birth date of deceased (mo., day, yr.) 1/1/1854 6.(c) If alive, give age _____ years

8. AGE: Years 93 Months 1 Days 15 If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business _____

12. Name Richard Hagner

13. Birthplace Washington D.C.

14. Maiden name Ann Hunsford

15. Birthplace Md.

16. Informant Mr. J. H. Hagner Jr

Address 707 Chumley Rd

17. buried Date thereof 2/21/1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Paul's

Location Chesic Frederick Md.

18. Funeral director J. J. Baker & Sons

Address 11 B. S. Light St.

19. 2/20 1947 A. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 1947 at 3 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 3 1947 to Feb 19 1947 and that I last saw him alive on Feb 19 1947

Immediate cause of death Cerebral Hemorrhage DURATION 1 day

Due to Senescent degeneration

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Antopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Gene Blower M. D. or other

Address Cecil Co. Date signed _____

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01388

Reg. Dist. No. 301

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 months, 4 years, 21 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital, 21 days
 How long in hospital or institution? 3 months, 4 years, 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County
 City or town Baltimore, 521 S. Charles Street
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Mae Hale

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed ?
 6. (b) Name of husband or wife Walter Hale
 6. (c) If alive, give age 59 years
 7. Birth date of deceased (mo., day, yr.) August 20, 1878
 8. AGE: Years 68 Months 5 Days 24 It less than one day hrs. min.

9. Birthplace Delaware
 (Town, county, and state)
 10. Usual occupation Domestic
 11. Industry or business Home
 12. Name Matthew Curall
 13. Birthplace Delaware
 14. Maiden name Elonea Weight
 15. Birthplace Easton, Maryland

16. Informant Hospital Records
Spring Grove State Hospital
 Address Catonsville 28
 17. Buried Date thereof 2-25-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Spring Grove State Hospital
 Location Catonsville, 28, Md.

18. Funeral director Spring Grove State Hospital
 Address Catonsville 28, Md.

19. 2-25-47 (Date rec'd by registrar) 19 47 Harry St. Miller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 13, 1947, at 11:55 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 19

Immediate cause of death Acute cardiac failure DURATION

Due to Chronic vascular disease

Due to fracture right femur

Other conditions due to a fall

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of Feb 7, 47

Where did injury occur? Catonsville (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) hospital

Means of injury fall to the floor Injured at work? no

23. SIGNATURE Geo. McKie M. D. or other Dr. McKie

Address 1010 Reed Ave Date signed 2-14-47

RECEIVED

FEB 27 1947

BUREAU OF

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

C1389

Reg. Diat. No. 420

1. PLACE OF DEATH

County Balto
 City or town Annapolis
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

1227 Lead Lane

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County BaltoCity or town Annapolis
 (If outside city or town limits, write RURAL and give nearest town)Street No. 1227 Lead Lane
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Harry Leo Hall

3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Pearl G. Keilholz7. Birth date of deceased (mo., day, yr.) July 13 1902 8.(c) If alive, give age 44 years8. AGE: Years 44 Months 7 Days 7 If less than one day hrs. min.9. Birthplace Ind
 (Town, county, and state)10. Usual occupation Real Estate Salesman11. Industry or business Luxford Real Estate12. Name Hall13. Birthplace not known14. Maiden name not known15. Birthplace not known16. Informant Mrs. Pearl G. HallAddress 1227 Lead Lane17. (Burial, cremation, or removal. Which?) Burial Date thereof Feb 24 47
 (month) (day) (year)Cemetery or crematory St. Mary'sLocation AAC Md18. Funeral director Harry A. DitzkeAddress 4401 Edmonson av19. July 22 47 G. Kieffer
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1947 at 4:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 47 to 19 47and that I last saw him alive on 19 47Immediate cause of death Coronary occlusionDue to Cardiovascular diseaseOther conditions pulmonary edema

(Include pregnancy within 3 months of death)

Major findings of operations agingDate of op. July 20 47Autopsy results aging

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of July 20 47

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G. Kieffer M. D. of IndAddress 1010 Lead Lane Date signed 2-20-47

RECEIVED

FEB 24 1947

BUREAU V B.

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

01390

P.
430

1. PLACE OF DEATH:

County Balto.City or town Overlea Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town (If outside city or town limits, write RURAL and give nearest town)Street No. 9 E Elm Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

4. Sex Male5. Color or race White6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Minnie L.7. Birth date of deceased (mo., day, yr.) Feb 19 18808.(c) If alive, give age 70 years8. AGE: Years 67 Months 4 Days 4 It less than one day hrs. min.9. Birthplace Addison New York
(Town, county, and state)10. Usual occupation Retired

11. Industry or business

12. Name Patrick M. Hanrahan13. Birthplace Ireland14. Maiden name ?15. Birthplace Ireland16. Informant Minnie L. HanrahanAddress 9 E. Elm Ave.17. Burial Date thereof 2-26-47
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Lorraine ParkLocation Woodlawn Md.18. Funeral director Martin W. E. Dippel: SAddress 7110 Belair Rd.19. 25 47 Registrar 25 47
(Date rec'd by registrar)

3.(b) Social Security Number

213-01-2048

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 1947 at 2: P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 1946 to February 1947and that I last saw him alive on 22 February 1947Immediate cause of death Coronary occlusion

DURATION

ImmediateDue to arteriosclerosis ?

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations noneDate of op. —Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [Signature] M. D. or otherAddress 2020 N. Charles St. Date signed 24 Feb

1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01391 300

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 17 days
 Hospital, institution, or street address where death occurred:
Nood Nursing Home 5501 Edmondson Ave
 How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Ohio County _____
 City or town Cuyahoga Falls
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2435 Front St
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Richard James Harkins

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Single

6. (b) Name of husband or wife.

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) July 29 - 1927

8. AGE: Years 19 Months 6 Days 16 If less than one day
 hrs. _____ min. _____

9. Birthplace Pittsburg Pa
(Town, county, and state)10. Usual occupation None

11. Industry or business

12. Name Rev. Raymond J. Harkins13. Birthplace Ohio14. Maiden name Lillian Elva Keay15. Birthplace Pa16. Informant Rev. Raymond J. HarkinsAddress 2435 Front St. Cuyahoga Falls Ohio

17. Removal Removal Date thereof Feb. 15, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory OakwoodLocation Cuyahoga Falls - Ohio18. Funeral director Mr. Mrs. John H. Gruefel & SonAddress 5311 Edmondson Ave19. Feb. 15 19 47 A.W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14 19 47 at 12 30 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 7 19 47 to Feb 14 19 47and that I last saw him alive on Feb 14 19 47Immediate cause of death Acute Coronary Failure DURATIONDue to Paroxysmal Tachycardia 3 daysTamoxifen Tachycardia

Due to _____

Other conditions Amnesia

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE James Howard M. D. or otherAddress Catonsville Date signed 2/14

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 381 8

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
(b) Street address: Baltimore
(c) Hospital or institution: Ind. College for Women
Lutherville, Md
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County Baltimore
(c) City or town Lutherville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Ind. College for Women
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Edward Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1888

8. AGE:

Years

Months

Days

If less than one day

59

hr.

min.

9. Birthplace

N. C.

(Town, county, and state)

10. Usual Occupation

Kitchen Helper

11. Industry or business

Girls School Lutherville

FATHER

12. Name

Samuel HarrisMd

13. Birthplace

N. C.

MOTHER

14. Maiden Name

Jessie Green

15. Birthplace

N. C.

16 (a) Informant

John Harris

(b) Address

Troy, N. Y.

17 (a)

Burial

(b) Date thereof

2/20/47

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Int. Calvary

Location

A. G. County, Md

18 (a) Funeral director

Joseph B. Locks, Jr.

(b) Address

1324 N. Central Ave

19 (a)

(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH

2/161947, at 8³⁰ A. M.

21. I certify that I took charge of the remains described above, held an

Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in myopinion resulted from: natural causes ☒ accident ☐ suicide ☐.homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Tuberculosis of lungs.Acute miliary tuberculosis.Due to Tuberculous cystitis.Syphilitic aortitis.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury..... at..... M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public

place?

While at work?

(d) Means of injury

23. Signature

George S. Merrill M.D.

Medical Examiner.

Date signed

2/17/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

Reg. Dist. No. 840

1. PLACE OF DEATH:

County..... Baltimore

City or town..... Rural-Middle River
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?.....
Hospital, institution, or street address where death occurred: 20
15-C Maple Drive, Oak Grove, Balto.

How long in hospital or institution?..... None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Baltimore

City or town..... Essex
(If outside city or town limits, write RURAL and give nearest town)Street No..... 15 C Maple Drive
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME

Ray C. Hatter

3.(b) Social Security Number

4. Sex..... 5. Color or race..... 6.(a) Single, married, widowed, or divorced.....

Male White Married

6.(b) Name of husband or wife..... Marie Hatter (nee Miller)

6.(c) If alive, give age..... 60 years

7. Birth date of deceased (mo., day, yr.)..... September 22, 1885

8. AGE: Years..... 61 Months..... 5 Days..... hrs..... min.

9. Birthplace..... Donaldson, Pa.
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name..... Charles L. Hatter

13. Birthplace..... Donaldson, Pa.

14. Maiden name..... Harriett Deiggs

15. Birthplace.....

16. Informant..... Mr. Ray C. Hatter, Jr.

Address..... 7 B Oak Grove Drive, Balto. 20, Md.

17. Removal..... Date thereof..... 2/26/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Misky Hill Cem.

Location..... Bethelhem, Pa.

18. Funeral director..... WM. J. TICKNER & SONS

Address..... Balto., Md.

19. 2/24 19 47 D. W. Hadwick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... February 22..... 19 47..... at 5:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
February 21..... 19 47..... to February 22 47
and that I last saw him alive on February 21..... 19 47.....

Immediate cause of death..... Coronary Occlusion..... DURATION.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Irving R Beck MD

Address..... 30 Chandelle Rd Balto 20..... Date signed..... 2/23/47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01394

Reg. Dist. No. 32

1. PLACE OF DEATH:
County Baltimore
City or town Pikesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? ?
Hospital, institution, or street address where death occurred:
Reisterstown Road, Pikesville-8, Md.
How long in hospital or institution? ?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Pikesville, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Reisterstown Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
George W. Hemling

3. (b) Social Security Number

4. Sex M. 5. Color or race W. 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) May 5, 1870 6.(c) If alive, give age years

8. AGE: Years 76 Months 9 Days 3 If less than one day hrs. min.

9. Birthplace Stevenson, Balto. Co., Md.
(Town, county, and state)

10. Usual occupation Painter

11. Industry or business

12. Name Fred Hemling

13. Birthplace Unknown

14. Maiden name Margaret Yingling

15. Birthplace Carroll County, Md.

16. Informant Pearl Whaley

Address Pikesville, Md.

17. Burial Date thereof Feb. 11, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Druid Ridge

Location Pikesville, Md.

18. Funeral director Wm. Berryman & Sons

Address Reisterstown, Md.

19. 2 - 10 - 1947 Dr. E. E. Nichols
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH February 8, 1947 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1945 to Feb. 8, 1947

and that I last saw him alive on Feb. 1st, 1947

Immediate cause of death DURATION

Coronary occlusion sudden

Due to

Due to Coronary Artery Disease 2 to 3
years

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. E. E. Nichols

M. D. or other

Address Pikesville, Md.

Date signed 2/10/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 11 1947
BUREAU V B
1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 632

01395

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County BaltimoreCity or town Perry Hall
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

1 Penn Ave

How long in hospital or institution?

3. (a) FULL NAME

Amelia Hoff

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

8. (b) Name of husband or wife

John P. Hoff

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

May 24th 1871

8. AGE:

Years

75

Months

8

Days

17

If less than one day

..... hrs.

..... min.

9. Birthplace

Germany

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

at Home

FATHER

12. Name

Unknown

13. Birthplace

Germany

MOTHER

14. Maiden name

"

15. Birthplace

"

18. Informant

Mrs Mary PoppeltAddress 1 Penn Ave, Perry Hall Md.

17. Burial

(Burial, cremation, or removal, which?)

Parkwood

Cemetery or crematory

Parkville Md.

Location

William Cook Inc.

18. Funeral director

Address 1217 St. Paul St.

19. Feb. 12

1947

(Date rec'd by registrar)

A.W. Friedrich

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md CountyCity or town Balto

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3602 Esther Place

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/11/47 at 9 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 16 1946, to 2/11 1947

and that I last saw him alive on

Immediate cause of death Cerebral Hemorrhage

DURATION

2 daysDue to arteriosclerosis & Hypertension

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE W. B. Bazzocchi MD

M. D. or other

Address 5829 Belair RdDate signed 2/11/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

01396

Reg. Dist. No. 301

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 22 yrs. 3 mos. 18 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 22 yrs. 3 mos. 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 736 South Linwood
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Charles Hoffman

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife _____
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) November 20, 1875
 8. AGE: Years 71 Months 2 Days 20 It less than one day _____ hrs. _____ min.

9. Birthplace Maryland
 (Town, county, and state)
 10. Usual occupation Furniture packer
 11. Industry or business Furniture
 FATHER 12. Name George Hoffman
 13. Birthplace Germany
 MOTHER 14. Maiden name ?
 15. Birthplace Germany
 16. Informant Hospital records
 Address Catonsville-28, Maryland

17. Burial Date thereof 2-13-1947
 (Burial, cremation, or removal, which?) (month) (day) (year)
 Cemetery or crematory Parkwood Cem.
 Location Taylor Ave.
 18. Funeral director Gilbert Zeiler Inc.
 Address 403 S. Wolfe St.
 19. 2-11 19 47 Isadore Tuerk Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9 19 47 at 8:45 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
October 22 19 24 to February 9 19 47
 and that I last saw him alive on February 9 19 47

Immediate cause of death Chronic myocarditis
 DURATION indefinite

Due to Arteriosclerotic heart disease

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

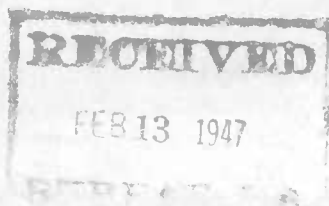
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Isadore Tuerk, M.D. M. D. or other _____Address Catonsville-28, Md. Date signed 2-10-47



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01397

Reg. Dist. No. 300

1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)Street No. 5 North Rolling Road
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

AMALIE C. HOHL

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Widowed6.(b) Name of husband or wife Conrad C. Hohl

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) December 7, 18628. AGE: Years 84 Months 1 Days 26 If less than one day _____ hrs. _____ min.9. Birthplace Germany
(Town, county, and state)10. Usual occupation Merchant11. Industry or business Market12. Name Henry Matheson13. Birthplace Germany14. Maiden name Helena Fredler15. Birthplace Germany16. Informant Mrs. Helen T. AlbrachtAddress 5 N. Rolling Rd. Catonsville17. Entombment February 6/47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Lorraine Park CemeteryLocation Woodlawn Md.18. Funeral director A. W. Hedrick & SonAddress 1300 Euteraw Place....1719. 2/6 47 A. W. Hedrick
(Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 2, 1947 19____, at 12:45A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan-28 1947, to Feb-2 1947
and that I last saw her alive on Feb-1- 1947

Immediate cause of death

Lobar Pneumonia

DURATION

5 days

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations None

Date of op. _____

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide NO Date of _____Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE S. Lloyd Johnson

M. D. or other

Address Catonsville Date signed 2-4-47
md.

PLEASE WRITE CLEARLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01398

Reg. Dist. No. 301

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1119 Darley Avenue
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

John W^M Hoover (John William Hoover)3. (b) Social Security Number
215-07-1088

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Margaret Jamison Hoover
 6. (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) September 6, 1882

8. AGE: Years 64 Months 5 Days 21 It less than one day _____ hrs. _____ min.

9. Birthplace Emmitsburg, Maryland
 (Town, county, and State)

10. Usual occupation Pumpman

11. Industry or business Standard Oil Company

12. Name Joseph Marcellis Hoover

13. Birthplace Emmitsburg, Maryland

14. Maiden name Mary Buckholtz

15. Birthplace Maryland

16. Informant Hospital records

Address Catonsville-28, Maryland

17. Burial Date thereof 3/3/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory New Cathedral Cemetery
Baltimore, Maryland

Location HENRY SANDER & SONS, INC.

18. Funeral director NORTH AVE. & BROADWAY

Address _____

19. March 1, 1947 A. N. Hedrick
 (Date rec'd by registrar) 1-35 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 28, 1947 at 1:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 25, 1947 to February 28, 1947
 and that I last saw him alive on February 28, 1947

Immediate cause of death Arteriosclerotic coronary heart disease
 DURATION indefinite

Due to _____

Due to _____

Other conditions Questionable tuberculosis of upper lobe, right lung
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results as above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Isadore Tuerk, M.D. M. D. or other _____

Address Catonsville-28, Md. Date signed 2-28-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

Reg. Dist. No. 81399 CXO

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 46 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Fort Howard, MarylandHow long in hospital or institution? 46 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 566 Gold Street

(If rural, give LOCATION)

2.(a) If veteran, name war WW-I

3. (a) FULL NAME

HARRY HOPEWELL

3. (b) Social Security Number

219-01-1250

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MaleColoredMarried6. (b) Name of husband or wife Estelle Hopewell7. Birth date of deceased (mo., day, yr.) 8-25-928. (c) If alive, give age 36 years8. AGE: Years 54 Months 5 Days 24 If less than one day9. Birthplace St. Mary's Co., Maryland

(Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

12. Name Jim Hopewell13. Birthplace ?14. Maiden name Mary ?15. Birthplace ?16. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Maryland17. Burial Date thereof 2/24/46

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Balto. NatLocation ind18. Funeral director Rev. S. KelsonAddress 1303 Pressman St19. 2-20-47 19 47

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 19, 19 47 at 2:20 a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 4, 19 47, to February 19, 19 47and that I last saw him alive on February 19, 19 47Immediate cause of death Disease of the Heart DURATION 2-1/2 Yrs.Cause: Coronary Arteriosclerosis and diabetes; Struct Lesionand Myocardial damage & pericarditisManif: Myocardial insufficiency

Due to

Other conditions Hypertension, arterial 3 Yrs.Diabetes mellitus 3 Yrs.Hemiplegia due to cerebrovascular 1-1/2 Mos.arteriosclerosis, generalized 3 Yrs.

Major incident of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert M. CollisonR. M. COLLISON, M. D. CLIN. M. PER.

Address Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

48-6

01400

Reg. Dist. No. 410

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Baltimore
 City or town Dundalk
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Dundalk
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 39 Broadship Road
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Marie S. Smekke

3. (b) Social Security Number

4. Sex

female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Howard E. Smekke

7. Birth date of deceased (mo., day, yr.)

February 4, 1899

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

48016

hrs.

min.

9. Birthplace

Littlestown, Pa.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Benjamin Smith

13. Birthplace

Pa.

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Mrs. Harold E. Smekke

Address

39 Broadship Road, Dundalk.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Feb. 24, 1947
(month) (day) (year)

Cemetery or crematory

Silver Run

Location

Carroll County

18. Funeral director

Roland E. Fisher

Address

2112 Dundalk Ave.

19.

(Date rec'd by registrar)

20.

Smekke

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20 1947, at 8:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 11946, toFeb. 201947and that I last saw him alive on Feb. 20 1947

Immediate cause of death

Carcinoma of uterus

DURATION

3 mo.

Due to

Carcinoma of uterus

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

E. R. Evans, M.D.

M. D. or other

Address

Liberty ParkwayDate signed 2-22-47

00010

STANDARD V. B.

RECEIVED

FEB 26 1947

BUREAU V. B.

1-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01401

Reg. Dist. No. 301

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 17 years, 8 mos., 23 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 17 years, 8 mos., 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2023 Rupp Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____ ☒

3. (a) FULL NAME

George Tamm (Bernard Jacobsen)

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced single
 6. (b) Name of husband or wife -
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) May 18, 1900
 8. AGE: Years 46 Months 9 Days 8 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Maryland
 (Town, county, and state)
 10. Usual occupation None
 11. Industry or business None
 FATHER 12. Name Max Jacobsen
 13. Birthplace ?
 MOTHER 14. Maiden name Jennie Schaks
 15. Birthplace ?

16. Informant Hospital records
 Address Catonsville-28, Maryland

17. Date thereof _____ (month) (day) (year)
 (Burial, cremation, or removal. Which?)
 Cemetery or crematory MICKRO-KODESH
 Location HERRING RUN
 18. Funeral director SOL LEVINSON & BROS
 Address 1124-26 W. NORTH AVE
 19. 2-27 147 Harry J. Miller
 (Date rec'd by registrar) Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 26 19 47 at 12:40a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ to _____ 19 _____
 and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death Acute Cardiac Failure
 Due to Bronch. Pneumonia
 Due to General Shock due to a fall on ice
 Other conditions Arteriosclerosis
Cerebral & arm (at elbow)
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide accident Date of Feb 22, 47
 Where did injury occur? Catonsville Baltimore
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) Hospital
 Means of injury fall on ice Injured at work? yes

23. SIGNATURE Geo. J. Kieffer M. D. or other _____
 Address 1010 Leaden Date signed 2-26-47

RECEIVED

MAR 8 1947

BUREAU V S

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01402 381
Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore
 City or town Towson 4, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Since February 4, 1947
 Hospital, institution, or street address where death occurred:
Eudowood Sanatorium, Towson 4, Md.
 How long in hospital or institution? Since February 4, 1947

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore City
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 725 N. Fox St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3. (a) FULL NAME

Agnes Hromadkova - Janda

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife deceased - Joseph
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) December 28, 1885
 8. AGE: Years 61 Months _____ Days _____ If less than one day _____ hrs. _____ min.
 9. Birthplace Czeckaslavakia
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business _____
 12. Name Michael Solly
 13. Birthplace Czeckaslavakia
 14. Maiden name Michalsky
 15. Birthplace Czeckaslavakia

Personal History - Hospital Records

16. Informant Eudowood Sanatorium, Towson 4, Md.
 Address _____
 17. Burial xxxx Holy Redeemer Date thereof 2/12/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory 4420 Belair Rd. Baltimore, Md.
 Location Charles E. Schimunek
 18. Funeral director 2601-03 E. Madison Street
 Address _____
 19. 2/12 19 47 A.W. Hedrich
 (Date rec'd by registrar) (year) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 8, 1947, at 9:10 P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 4, 1947 to February 8, 1947
 and that I last saw him alive on February 8, 1947
 Immediate cause of death Pulmonary tuberculosis
 DURATION about 1 1/2 years
 Due to _____
 Due to _____
 Other conditions Cardio circulatory failure
 (Include pregnancy within 3 months of death) about 2 months
 Major findings of operations _____
 Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE W.A. Bridges M. D. or other _____
 Address Towson 4, Maryland Date signed 2-8-47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

01403

440

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 105 Days
 Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland
 How long in hospital or institution? 105 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 423 East Street
 (If rural, give LOCATION)
 2. (a) If veteran, name war WW-I ✓

3. (a) FULL NAME

CLIFFORD L. JENKINS

3. (b) Social Security Number

217-20-7113

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife Single.
 6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) 7-12-1895

8. AGE: Years 51 Months 7 Days 2 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Maryland
 (Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business _____

FATHER 12. Name Joseph Jenkins
 13. Birthplace Baltimore, Md.

MOTHER 14. Maiden name Marion Staylor
 15. Birthplace Hamilton, Md.

16. Informant Clinical Records, Vets. Adm. Hosp.
Fort Howard, Maryland
 Address _____

17. Burial Date thereof Feb 18-1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Balto National
 Location Baltimore Maryland

18. Funeral director Esauworth Armbrust
 Address 3911 Liberty Heights Ave
2/17 47

19. (Date rec'd by registrar) _____ Registrar Dr. J. D. Hedrick

MEDICAL CERTIFICATION

20. DATE OF DEATH February 14, 1947 at 7:55 a. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1, 1946 to February 14, 1947
 and that I last saw him in alive on February 14, 1947

Immediate cause of death ARTERIOSCLEROSIS OF
CEREBRAL VESSELS WITH MULTIPLE SMALL
INFARCTS OF THE BRAIN.

DURATION

3 1/2 mos.Plus

Due to _____

Other Conditions: Arteriolosclerotic
Nephritis

Unknown

Other conditions Hypertension with Hyper-
trophy of left Ventricle of the Heart
 (Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results Substantiated Above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE H. J. Fort M. D. or other _____

Address V.A.H. Fort Howard, Md. Date signed 2-14-47

PLEASE WRITE

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 420

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 99 Oakleigh Village

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 61 yr

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Calvert

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 99 Oakleigh Village

(If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME

John Roland Jester

3 (b) If veteran, name war

3 (c) Social Security Account

No - 215-09-3788

4. Sex

male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife Caroline Jester

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Nov-19-1882

8. AGE: Years

Months

Days

If less than one day

64

3

-

hr.

min.

9. Birthplace

Kent Co. Ind.

(Town, county, and state)

10. Usual Occupation

retired - Supv

11. Industry or business

Baltimore Transit Co

FATHER

12. Name

John L. Jester

13. Birthplace

Kent Co. Ind.

MOTHER

14. Maiden Name

Lucinda Sylvester

15. Birthplace

Kent Co. Ind.

16 (a) Informant

Caroline Jester

(b) Address

99 Oakleigh Village

17 (a)

Burial

(b) Date thereof

Feb 22/47

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematorium

Landon Park

Location

Baltimore, Md

18 (a) Funeral director

F. B. Whippert & Son

(b) Address

1300 Eastman Pl.

19 (a)

2120/47

C. M. Hedrick

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 - 1947, at 5:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from February 22, 1946, to 2-19-1947, and that I last saw him alive on February 18, 1947.

Immediate cause of death

organic heart disease

Duration

unknown

Due to Hypertension

unknown

Due to

Other Conditions Glenoid

1 month

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

PHYSICIAN

Underline the cause to which death should be charged statistically.

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Chester Roland

M. D.

Address 2532 Edmondson Ave Date signed 2-19-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (RA)

CERTIFICATE OF DEATH

Reg. Dist. No. 01405420

1. PLACE OF DEATH: Balto
 County Lansdowne
 City or town Lansdowne
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
2923 Balto. Ave
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Md County Balto.
 City or town Lansdowne
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2923 Balto. Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Paul Ray Jones

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Sept 28th 1946 6.(c) If alive, give age _____ years

8. AGE: Years 4 Months 26 Days 5 If less than one day _____ hrs. _____ min.

9. Birthplace Balto. Md.
 (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Carl H. Jones

13. Birthplace Parsons W. Va.

14. Maiden name Dorothy Claribel

15. Birthplace W. Va.

16. Informant Carl H. Jones

Address 2923 Balto. Ave - Lansdowne

17. Burial (Burial, cremation, or removal-Which?) Burial Date thereof 2/26/47
 (month) (day) (year)

Cemetery or crematory Mt. Carmel

Location Balto. Md.

18. Funeral director William Cook Inc.

Address 1217 S. Paul St. Balto. 2 Md.

19. Thy 24 19 47 Th Kieffer
 (Date recd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24th 1947 at 12:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 18 _____, to _____ 19 _____

end that I last saw him _____ alive on _____ 19 _____

Immediate cause of death Suffocation

Due to by old covers

Due to in sleep

Other conditions Accident

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide Accident Date of Feb 24/47

Where did injury occur? Lansdowne Balto. Md.
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) home

Means of injury Covered by bed covers Injured at work?

23. SIGNATURE Th Kieffer M. D. Th Kieffer

Address 1000 Leachman Date signed Feb 24/47

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

MAR 4 1947

BUREAU V S.

2-35

STATE OF MARYLAND—CERTIFICATE OF DEATH

01406

1. PLACE OF DEATH

County

Baltimore

Village or City

Sparrow Point

No.

Registration Dist. No.

410

St.

Ward

Length of residence in city or town where death occurred

17 yrs.

mos.

ds.

How long in U.S. If of foreign birth?

ys.

mos.

ds.

2. FULL NAME

George William Kappel

(a) Residence: No.

Box # 305

(Usual place of abode)

Woodward Terrace

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

Emma Kappel

6. DATE OF BIRTH (month, day, and year)

Dec 7 / 1875

7. AGE

Years

Months

Days

If LESS than

1 day, hrs. or min.

71

2

10

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BODKKEEPER, etc.

Stock Clerk (Retail)

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

Bank Shelf Tea

10. Date deceased last worked at this occupation (month and year)

July 45

11. Total time (years) spent in this occupation

35

12. BIRTHPLACE (city or town) (State or country)

Baltimore Md.

MOTHER FATHER

13. NAME

14. BIRTHPLACE (city or town) (State or country)

15. MAIDEN NAME

16. BIRTHPLACE (city or town) (State or country)

17. INFORMANT (Address)

Alden Kappel - 2518 1st Pky Dundalk Md

18. BURIAL, CREMATION, OR REMOVAL

Place Catholic National Cemetery Date Feb. 24, 1947

19. UNDERTAKER (Address)

Coland R. Fisher 311 Dundalk Ave

20. FILED

4/23/47 J. McLean Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

Feb. 22, 1947 (Month) (Day) (Year)

22.

I HEREBY CERTIFY That I attended deceased from Feb. 22, 1947, to Feb. 22, 1947

I last saw him

alive on

Dec. 1, 1947

; death is said

to have occurred on the date stated above, et. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Coronary Occlusion

Date of onset

Immediate

Other Contributory Causes of importance:

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide?

Date of injury

19

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) J. McLean M.D. (Address) Deputy Medical Examiner Dundalk Md.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>
Other contributory causes of importance:	
<i>Gallstones</i>	<i>May 1, 1923</i>

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>
Other contributory causes of importance:	
<i>Gastroenteritis</i>	<i>1 year</i>

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01407

BC
Reg. Dist. No. 300

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 years, 8 months, 5 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 2 years, 8 months, 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 431 South Hornel Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

F.
Marie Kessler (Mary Lang)

3. (b) Social Security Number

NONE

4. Sex

female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Paul Joseph Kessler

7. Birth date of deceased (mo., day, yr.)

February 21, 1887

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

60

-

7

hrs.

min.

5. Birthplace

Baltimore, Maryland
 (Town, county, and state)

10. Usual occupation

Defense work

11. Industry or business

War plant

MOTHER FATHER

12. Name

John Sachs

13. Birthplace

Baltimore, Maryland

14. Maiden name

Anna Martz

15. Birthplace

Baltimore, Maryland

16. Informant

Hospital records

Address

Catonsville-28, Maryland

17.

Burial
 (Burial, cremation, or removal, which)

Date thereof

3/5/47
 (month) (day) (year)

Cemetery or crematory

Oak Lawn

Location

Eastern Ave. Extended

18. Funeral director

William Cook Inc.

Address

1217 St. Paul St.

19.

March 4 47
 (Date rec'd by registrar)

A. W. Hedrick
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 28 19 47 at 3:45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 2319 44, to February 28 19 47and that I last saw him alive on February 28 19 47

Immediate cause of death

Right pyelitis; Escherichia coli
--proteus vulgaris and proteus

Due to mirabilis--

Due to Luetic transverse myelitis of
the cord

Other conditions Central nervous system
lues.

(Include pregnancy within a year of death)

Major findings of operations

Date of op. _____

Autopsy results

as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Isadora Tuerk, M.D.

M. D. or other

Address Catonsville 2-8, Md. Date signed 2-28-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13-6

CERTIFICATE OF DEATH

Reg. Dist. No. 420

1. PLACE OF DEATH:

County Arboretus
4318 Leeds Ave
City or town Baltimore Md
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. 4318 Leeds Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William Elmer Klein

3. (b) Social Security Number

212-03-8156

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male white married6.(b) Name of husband or wife Ruby E. Klein6.(c) If alive, give age 39 years7. Birth date of deceased (mo., day, yr.) July 28 - 18998. AGE: Years 47 Months 6 Days 28 If less than one day
hrs. min.9. Birthplace Baltimore Md
(Town, county, and state)10. Usual occupation Glass Worker -11. Industry or business Glass12. Name Charles Klein13. Birthplace Baltimore Md14. Maiden name Baltimore Harbor House15. Birthplace Baltimore Md

16. Informant

Address

17. Burial Date thereof 2-28-47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory London ParkLocation Leeds Ave - Baltimore Md18. Funeral director Oakwood Funeral Home IncAddress 403 - E - 25th St19. 2/28/47
(Date read by registrar)19. 47D.W. Redick
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25 1947 at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1945 to Feb 25 1947
and that I last saw him alive on February 25 1947

Immediate cause of death

DURATION

Pulmonary Tuberculosis27 mos

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address 4001 Wilkens Ave Date signed 2-25-47

MARGIN RESERVED FOR BINDING

9-45-15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01409

Reg. Dist. No. 330

1. PLACE OF DEATH:

County Baltimore
 City or town Reisterstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 23 yrs
 Hospital, institution, or street address where death occurred:
Reisterstown Road
 How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md County Baltimore
 City or town Reisterstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Reisterstown Rd
 (If rural, give LOCATION)
 2.(a) If veteran, name war No

3.(a) FULL NAME

Charles Oliver Knight

3.(b) Social Security Number

None

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

M

MEDICAL CERTIFICATION

20. DATE OF DEATH February 26 1947 at 3:50 P.M.8.(b) Name of husband or wife Anna May Hendricks Knight

7. Birth date of deceased (mo., day, yr.) October 5 1881
 8.(c) If alive, give age 55 years

8. AGE: Years 65 Months 4 Days 21 It less than one day
hrs.min.

9. Birthplace Baltimore Md
 (Town, county, and state)

10. Usual occupation Sign Painter

11. Industry or business

12. Name Louis Knight13. Birthplace Germany14. Maiden name Margaret E Roehe15. Birthplace Baltimore Md16. Informant Charles O Knight JrAddress Reisterstown Md

17. Burial Date thereof Feb 28 1947
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Lorraine Park CemeteryLocation Baltimore Md18. Funeral director Wm Berryman & SonsAddress Reisterstown Md

19. 2-27- 1947 Mary A Elmer
 (Date rec'd by registrar) Registrar

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
1-11-'46 19....., to 2-25-'47 19.....

and that I last saw him alive on 2-25-'47 19.....

Immediate cause of death

Ca. of caecum

DURATION

1 yr.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

NONE

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? NONE
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE D. D. Caples, M.D.

M. D. or other

Address Reisterstown, Md. Date signed 2-26-47

RECEIVED

MAR 3 1917

BUREAU V. B.

1-38

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 420

1. PLACE OF DEATH:

County Baltimore

City or town Abutts
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Abutts
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1207 Elm Ridge Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

George William Koehler

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife Catherine (Reichert)

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Jan. 18, 1876

8. AGE: Years 71 Months 0 Days 26 If less than one day..... hrs. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual occupation Clerk

11. Industry or business B & O R.R.

12. Name George Koehler

13. Birthplace Baltimore

14. Maiden name Lauria Hesse

15. Birthplace Baltimore

16. Informant Mrs. Catherine Koehler

Address 1207 Elm Ridge Rd

17. (Burial, cremation, or removal, which?) Burial Date thereof Feb. 7, 1947
(month) (day) (year)

Cemetery or crematory Landon Park

Location 3801 Frederick Ave

18. Funeral director Harry H. Witzke

Address 4101 Elmwood Ave

19. 2/5/47 19.....
(Date of death) (month) (day) (year) Registrar R. W. Hedrick

MEDICAL CERTIFICATION

20. DATE OF DEATH February 4 19 47 at 10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 46 to Feb 4 19 47

and that I last saw him alive on Feb 3 19 47

Immediate cause of death Cardio-vascular degenerative disease
pulmonary infarct DURATION 1942
2 yrs

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations Benign Prostatic Hyperplasia
Date of op. July 5, 1946

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Harold Pass, M.D.

Address 4001 W. Shaws Ave M. D. or other

Date signed 2-4-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1411 500

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 mo - 17 days
 Hospital, institution, or street address where death occurred:
5313 Edmondson Ave
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State md County Baltimore
 City or town Halethorse
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1810 Arbuckle Ave
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

John W. Roontz

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, or divorced Married
 6.(b) Name of husband or wife Ida Florence
 7. Birth date of deceased (mo., day, yr.) December 28, 1869 6.(c) If alive, give age _____ years
 8. AGE: Years 77 Months 1 Days 3 If less than one day _____ hrs. _____ min.

9. Birthplace Vi. (Town, county, and state)
 10. Usual occupation Retired (Inspector B.O.R.R.)
 11. Industry or business

12. Name unknown
 13. Birthplace unknown
 14. Maiden name unknown
 15. Birthplace unknown
 16. Informant Dr Lloyd M. B. Roontz
 Address 101 Winkler Rd
 Removal 3/4/46
 17. (Burial, cremation, or removal, Which?) Date thereof (month) (day) (year)
 Cemetery or crematorium Woodlawn
 Location Harrisonburg Va.
 18. Funeral director Wm. J. Jackson & Sons
 Address North & Va. Aves
 19. (Date rec'd by registrar) 2-3-47 Registrar Wm. J. Jackson

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/11 1947 12 0 45 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 20 1946 to Feb 1 1947
 and that I last saw him alive on Feb 1 1947

Immediate cause of death Cerebral Thrombosis DURATION 3 days
 Due to Cerebral Arterio Sclerosis
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Wm. J. Jackson M. D. or otherAddress Catonsville Date signed 2-2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 410

01412

1. PLACE OF DEATH:

County Baltimore
City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 95 Days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland
How long in hospital or institution? 95 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Cecil
City or town Ridgely
(If outside city or town limits, write RURAL and give nearest town)
Street No. None
(If rural, give LOCATION)
2. (a) If veteran, name war PTE & WW-I

3. (a) FULL NAME

JAMES A. KORNRUMPT

3. (b) Social Security Number

213-22-8983

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Agnes Kornrumpt
6. (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) 3-2-92
8. AGE: Years 54 Months 11 Days 3 If less than one day _____ hrs. _____ min.

9. Birthplace Brooklyn, N. Y.
(Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

FATHER 12. Name Emil Kornrumpt
13. Birthplace Detroit, Mich.

MOTHER 14. Maiden name Rose O'Neil
15. Birthplace Brooklyn, N. Y.

16. Informant Clinical Records, Vets. Adm. Hosp.
Address Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Feb 9, 1947
(month) (day) (year)
Cemetery or crematory Denton, Md.
Location V. Virgin

18. Funeral director Denton, Md.
Address Denton, Md.

19. (Date rec'd by registrar) 2/14/47 Registrar M. J. Parson

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5, 1947 at 11:25 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 2, 1947 to February 5, 1947
and that I last saw him alive on February 5, 1947

Immediate cause of death Bronchopneumonia, bilateral DURATION 7 Days

Due to _____

Due to _____

Other conditions Degenerative disease of the spinal cord, cause undet. 27 Yrs.

Decubitus ulcer over sacrum and buttocks
Major findings of operations 5 Months.

Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert M. Cullison
R.M. CULLISON, M.D. CLIN. M. DIR.
Address V.A. Ft. Howard, Md. Date signed 2-6-47

MARGIN RESERVED FOR BINDING

9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 13 1947

BUREAU V L

2-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlee St., Baltimore *MD*

CERTIFICATE OF DEATH

Reg. Dist. No. *01413*
37

1. PLACE OF DEATH:

County *Baltimore*
City or town *Texas*
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? *2 yr. 9 mo. 18 da.*
Hospital, institution, or street address where death occurred:
Baltimore County Home
How long in hospital or institution? *2 yr. 9 mo. 18 da.*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State *Maryland* County *Balto*
City or town *Texas*
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war. ☒

3. (a) FULL NAME

William. H. Kosman

3. (b) Social Security Number

☒

4. Sex *male* 5. Color or race *white* 6.(a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) *Aug. 3, 1863* 6.(c) If alive, give age _____ years

8. AGE: Years *83* Months *6* Days *18* If less than one day _____ hrs. _____ min.

9. Birthplace *Maryland*
(Town, county, and state)

10. Usual occupation *Stone cutter*

11. Industry or business

12. Name *Frederick Kosman*

13. Birthplace *Germany*

14. Maiden name *Ann Grodwin*

15. Birthplace *Ireland*

16. Informant *Wilson J. Carroll Jr.*

Address *221 East 25th St. Md.*

17. *Burial* Date thereof *2-24-47*
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Baltimore County Home*

Location *Texas Md.*

18. Funeral director *Landon M. Brooks*

Address *Sparks Md.*

19. *Feb 20* 19 *47* *Wm J. Chilcoat*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Feb 20* 19 *47* at *11 A.* *46* *M*

21. I CERTIFY that death occurred on the date above stated; that *deceased* deceased from *May 2* 19 *44* to *Feb 20* 19 *47*

and that I last saw him *alive* on *Feb. 19* 19 *47*

Immediate cause of death *Myocarditis* DURATION *1 yr.*

Due to *Chronic Nephritis* *3 yrs.*

Due to _____

Other conditions *Sec. Anemia -*

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

SIGNATURE *Wilmer C. Evers M.D.* M. D. or other

Address *Croftonville Md.* Date signed *2/20/47*

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 4 1947
BUREAU V. E.

2-25

2-370 — 2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Haase
4218 Harford Road

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 937

CERTIFICATE OF DEATH

01414

Reg. Dist. No.

1. PLACE OF DEATH:

County Parkville
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

3022 Woodside Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto. Co.
Parkville

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3022 Woodside Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Jennie Pike Kreadle

3. (b) Social Security Number

4. Sex female 5. Color or race w white 6.(a) Single, married, widowed, or divorced married
6.(b) Name of husband or wife Henry O. Kreadle
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 25, 1877
8. AGE: Years 69 Months 2 Days 13 If less than one day hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation at home

11. Industry or business

MOTHER FATHER 12. Name Francis G. Shannon
13. Birthplace Md.

MOTHER 14. Maiden name Annie Norris
15. Birthplace Md.

16. Informant Mr. Henry O. Kreadle
Address 3022 Woodside Avenue

17. Burial 2/10/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Lorraine Park
Location Baltimore, Md.

18. Funeral director Leonard J. Ruck
Address 5305 Harford Road

19. (Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6th, 19 47 at 11 45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 19 46 to Feb. 19 47
and that I last saw h. or alive on Feb. 6 19 47

Immediate cause of death Acute pulmonary edema DURATION

Due to arteriosclerotic cardiac-vascular disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations none Date of op.

Autopsy results none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE J. Henry Haase M. D. or other
Address 4218 Harford Rd Date signed Feb 7, 1947

Evidence for the addition of items
5, 6 is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01415

CERTIFICATE OF DEATH

Reg. Dist. No. 381

FILM No. G 109 APR 17 1947

1. PLACE OF DEATH:

County Baltimore
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

10 W Burke Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)

Street No. 10 W Burke Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Estelle Elizabeth Lawrence

3. (b) Social Security Number

4. Sex

White

5. Color or race

Female

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Judge H. Lawrence

7. Birth date of

deceased (mo., day, yr.)

Oct 26 1880

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

66

hrs. min.

9. Birthplace

Baltimore Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

Housewife

FATHER

12. Name

Louis E Russell

13. Birthplace

Germany

MOTHER

14. Maiden name

Jennett Hannenwetsch

15. Birthplace

Baltimore Md

16. Informant

Lenore Russell

Address

10 A West Burke Ave

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Grundy Ridge

Location

Pikesville

18. Funeral director

Address

John A Moran

19.

(Date rec'd by registrar)

19

47

19

47

19

47

23. SIGNATURE

R. H. Quinn

M. D. or other

Address

4 Bumblebee St.

Date signed

10 Feb 47

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 9 19 47 at 9:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 40 to 9 Feb. 19 47and that I last saw her alive on 9 Feb. 19 47

Immediate cause of death

Cerebral Hemorrhage

DURATION

11 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

R. H. Quinn

M. D. or other

Address

4 Bumblebee St.

Date signed

10 Feb 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age, sex, 5, 6 is shown on is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 19 1947

BUREAU N

2-25

2-380-2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

01416

410

1. PLACE OF DEATH
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME
 JOHN W. LAWRENCE

3. (b) Social Security Number

4. Sex.....
 5. Color or race.....
 6. (a) Single, married, widowed, or divorced.....

6. (b) Name of husband or wife.....
 6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.).....

8. AGE: Years..... Months..... Days.....
 If less than one day..... hrs. min.

9. Birthplace.....
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. (Burial, cremation, or removal, Which?).....
 Date thereof..... (month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. (Date rec'd by registrar).....
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....
 and that I last saw him alive on.....

Immediate cause of death.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

Address.....

Date signed.....

RECEIVED

FEB 26 1947

BUREAU V A

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 381

1. PLACE OF DEATH:

County... Balto.

City or town... Idlewylde
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
919 Arran Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... Balto.

City or town... Idlewylde
(If outside city or town limits, write RURAL and give nearest town)Street No... 919 Arran Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

JOSEPH D. LEE

3. (b) Social Security Number

none

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife... Jessie M. Lee

7. Birth date of

deceased (mo., day, yr.)

Nov. 1, 1868

6. (c) If alive, give age... years

8. AGE:

Years

Months

Days

If less than one day

78

3

27

hrs.

min.

9. Birthplace... China

(Town, county, and state)

10. Usual occupation

Laundry - retired

11. Industry or business

FATHER

12. Name

Lee York

13. Birthplace

China

MOTHER

14. Maiden name

unknown

15. Birthplace

China

16. Informant

Mrs. Jessie M. Lee

Address

919 Arran Rd.

12

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

Mar. 3, 1947

(month) (day) (year)

Cemetery or crematory

Parkwood Cem.

Location

Balto., Md.

18. Funeral director

WM. J. TICKNER & SONS

Address

Balto., Md.

19.

March 3, 1947
(Date rec'd by registrar)

19

47

R. W. Hedrick
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Feb. 28, 1947, at... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 15, 1946, to Feb. 28, 1947, and that I last saw him alive on Feb. 28, 1947.

Immediate cause of death

DURATION

Coronary Atherosclerosis

Due to

Myocardial Infarction

Due to

Sudden

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address... 5407 Belvidere St. Date signed... 3-28-47

Evidence for change of age + birthdate shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01418

7

FILE NO. G 110 JUN 5 1947 CERTIFICATE OF DEATH

Reg. Dist. No.

430

1. PLACE OF DEATH:

County Baltimore Co Md
City or town Overlea Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Balt Co
City or town Overlea Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7420 Beach Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

James Henry Lewis

3. (b) Social Security Number

4. Sex M 5. Color or race Colored 6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

Susie

7. Birth date of deceased (mo., day, yr.)

March 15, 1862

8. AGE:

67 Years 85 Months 11 Days 2 If less than one day hrs. min.

9. Birthplace

Caroline Co Va
(Town, county, and state)

10. Usual occupation

So. Farm

11. Industry or business

FATHER
MOTHER

12. Name

Henry Lewis

13. Birthplace

Caroline Co Va

14. Maiden name

Va

15. Birthplace

Susie Taylor

16. Informant

Mary Lewis

Address

7420 Beach Ave Overlea Md

17.

Burial

Date thereof

Feb 22, 1947
(month, day, year)

Cemetery or crematory

Int. Calvary Cemetery

Location

A A Co Md

18. Funeral director

Prof. E. Williams

Address

1515 Mc Elder

19.

2/21

1947

A. W. Friedrich
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17 19 47 at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 16 19 47 to Feb 17 19 47

and that I last saw him alive on Feb 17 19 47

Immediate cause of death

Myocardial Infarction

DURATION

Sudden

Due to

Arterio-sclerotic-Cardiovascular disease

Due to

Other conditions

Diabetes mellitus

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Geo. M. Baumgardner

M. D. or other

Address

Balt Co

Date signed 2-17-47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01419

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 12 years, 4 months, 13 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution?..... 12 years, 4 months, 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....
 City or town..... Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 2007 W. Balto. St
 (If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (a) FULL NAME

Abbie Link

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

George Link

7. Birth date of

deceased (mo., day, yr.)

Jan. 10, 1894

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

It less than one day

5513

hrs.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Home

FATHER

12. Name

William Moran

13. Birthplace

Ireland

MOTHER

14. Maiden name

Abbie (unknown)

15. Birthplace

Ireland

16. Informant

Hospital Records,Address Catonsville, 28, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Feb. 15, 1947

Cemetery or crematory

New Cathedral

Location

Baltimore

18. Funeral director

Frederick A. Gole

Address

1208 W. Lombard St

19.

(Date rec'd by registrar)

19

A. W. Hedrick

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... February 13..... 19 47..... at 9:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 1, 1934..... 19..... to February 13, 1947.....and that I last saw him/her alive on February 13, 1947..... 19.....

Immediate cause of death

Aplastic Anemia(Macrocytic type.)

DURATION

Indefinite

Due to.....

Due to.....

Other conditions..... Subacute combined degenerationIndef.

(Include pregnancy within 3 months of death)

Major findings of operations.....

None

Date of op.

Autopsy results.....

None held

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE.....

Henry C. A. Mead, M.D.Address Catonsville, 28, Md.Date signed 2/13/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01420

P

300

Reg. Dist. No.

1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore, 14
(If outside city or town limits, write RURAL and give nearest town)Street No. 4703 Walter Boulevard
(If rural, give LOCATION)

2. (a) If veteran, name was

3. (a) FULL NAME

Emma May Nigl Linton

3. (b) Social Security Number

4. Sex

female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

separated6. (b) Name of husband or wife Herman O. Linton6. (c) If alive, give age 41 years7. Birth date of deceased (mo., day, yr.) Sept. 30, 19058. AGE: Years 41 Months 4 Days 18 If less than one day hrs. min.9. Birthplace Baltimore, Maryland
(Town, county, and state)10. Usual occupation at home

11. Industry or business

12. Name John J. Nigl13. Birthplace Maryland14. Maiden name Mamia E Gunther15. Birthplace Maryland16. Informant Hospital RecordsAddress Catonsville, 28, Md.17. Burial Date thereof 2/21/47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory OaklawnLocation Baltimore18. Funeral director Leonard J. RuckAddress 5305 Harford Road19. 2-20 (Date rec'd by registrar)9. 2-20 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 18, 1947 19..... at 3:00P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 13, 1946 19..... to February 18, 1947 19.....and that I last saw him or alive on February 18, 1947 19.....Immediate cause of death Cerebral hemorrhage
(cause undetermined)

DURATION

3 hoursDue to Bilateral pulmonary infarc
tion (embolic?)72 hrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Broken neck, n.s. Injured at work?23. SIGNATURE Isadore Tuark, M. D.

M. D. or other

Address Catonsville, 28, Md. Date signed 2/18/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 57

01421

1. PLACE OF DEATH:

County Baltimore
 City or town Sparks
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Baltimore
 City or town Sparks
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Fannie Madden

3. (b) Social Security Number

4. Sex

F

5. Color or race

colored

6. (a) Single, married, widowed, or divorced

widow

B. (b) Name of husband or wife.

John H. Madden

7. Birth date of deceased (mo., day, yr.)

May 19 1872

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

74816

hrs.

min.

9. Birthplace

Sparks, Balto. Co. Md.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

house

MOTHER

12. Name

John H. Madden

13. Birthplace

Balto. Co. Md.

14. Maiden name

Elizabeth

15. Birthplace

Balto. Co. Md.

16. Informant

Mabel Madden Johnson

Address

Sparks, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Burial Feb. 6-47
(month) (day) (year)

Cemetery or crematory

Stephenson A.M.E.

Location

Sparks, Md.

18. Funeral director

Samuel M. Brooks

Address

Sparks, Md.

19.

(Date rec'd by registrar)

19.

2-5

47

Wilmer C. Ensor

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 7 19 47 at 5:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

September 19 46 to February 19 47and that I last saw him alive on January 27 19 47

Immediate cause of death

Respiratory + cardiac

Due to

arteriosclerotic cardiac

Due to

+ generalized arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE

Elizabeth B. Shindler, M.D.
M. D. or otherAddress Cockeysville, Md. Date signed 2/4/47

RECEIVED

FEB 7 1947

BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 01422 4X1

1. PLACE OF DEATH:

County BaltimoreCity or town Essex - Baltimore
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balt.City or town Essex - Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 8 Back River Neck Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

MARY MARCIN

3. (b) Social Security Number

4. Sex F 5. Color or race W. 6. (a) Single, married, widowed, or divorced Married8. (b) Name of husband or wife Thomas Marcin7. Birth date of deceased (mo., day, yr.) not know 1888 6. (c) If alive, give age _____ years8. AGE: 69 Years Months Days If less than one day _____ hrs. _____ min.9. Birthplace Lithuanian
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Matthew Valinskas13. Birthplace Lithuanian14. Maiden name Teronca Valinskas15. Birthplace Lithuanian16. Informant Mr. Thomas MarcinAddress 8 Back River Neck Road17. Burial Date thereof 2-13-47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Holy RedeemerLocation 4430 Belair Road18. Funeral director John A. Strebliouckas Jr.Address 423 S. Paca St.19. 2/12/47 19. 47
(Date recd. by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10 1947 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____, to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death Coronary Occlusion DURATION 10 min.Due to Hypertensive C-V DiseaseDue to Diabetes 10 yrs

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE M. B. Davis M.D.Address Dup. Md. Examiner Baltimore Date signed 2/12/47

1947
1888
1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95-4

CERTIFICATE OF DEATH

Reg. Dist. No. 01423 330

1. PLACE OF DEATH
 County Baltimore
 City or town Boring
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Boring
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME
Rachel J. Markland

3. (b) Social Security Number
✓

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Frank Markland

7. Birth date of deceased (mo., day, yr.) August 7-1859 6. (c) If alive, give age 81 years

8. AGE: Years 87 Months 6 Days 15 If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
 (Town, county, and state)

10. Usual occupation Shop.

11. Industry or business

12. Name Andrew Jackson
 13. Birthplace Maryland

14. Maiden name Arianna Ryan
 15. Birthplace McKeesport

16. Informant Frank Markland
 Address Boring, Md

17. Burial Date thereof Feb 26/47
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Mt Carmel
 Location Belts Co. Md

18. Funeral director Edw. G. Gipton
 Address Hampstead, Md

19. 2-24 1947 Mary B. E. Kline
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/22/47 1947 at 9:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/1/43 to 2/22/47 and that I last saw her alive on 2/21/47

Immediate cause of death myocardial infarction
hypertension

Due to _____
 Due to _____

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following; ✓
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____
 Means of Injury _____ Injured at work? _____

23. SIGNATURE Rachel J. Markland _____
 Address _____ Date signed 2/25/47

RECEIVED
MAR 3 1947
BUREAU OF

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-2

CERTIFICATE OF DEATH

01424

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Balto.City or town Bundalk
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

237 Baltimore Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Balto.City or town Bundalk
(If outside city or town limits, write RURAL and give nearest town)Street No. 237 Baltimore Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Elizabeth May Martin

3. (b) Social Security Number

4. Sex

F

Color or race

W

6. (a) Single, married, widowed, or divorced

divorced

8. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

Feb. 28 - 1902

8. AGE:

Years

Months

Days

If less than one day

441122

hrs.

min.

9. Birthplace

Va.

(Town, county, and state)

10. Usual occupation

at home

11. Industry or business

FATHER

12. Name

Wm. Atkins

13. Birthplace

Va.

MOTHER

14. Maiden name

Brooks

15. Birthplace

Va.

16. Informant

Reba Ake

Address

237 Balto. Ave. (Daughter)

17.

(Burial, cremation, or removal. Which?)

Burial

Date thereof

2/10/47
(month) (day) (year)

Cemetery or crematory

Sacred Heart

Location

German Hill Rd.

18. Funeral director

John H. Connelly

Address

418 Eastern Ave. Balto. 21.

19.

(Date rec'd by registrar)

19

47

19

John H. Connelly

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 619 47, at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan

19

45

to

Feb. 6

19

47and that I last saw h. er alive onFeb. 6

19

47

Immediate cause of death

uremia

DURATION

3 days

Due to

Chronic nephritis10 yrs

Due to

Hypertension10 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

David H. Andrew M.D.

M. D. or other

Address

2 Kennedy Rd

Date signed

2/10/47Bundalk md

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

161a

01425

CERTIFICATE OF DEATH

Reg. Dist. No.

441

1. PLACE OF DEATH:

County Balto.
City or town Middle River 1613 Rickenbacker
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County Balto.
City or town Middle River
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1613 Rickenbacker Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Newborn - McMahon
4. Sex m 5. Color or race w 6.(a) Single, married, widowed, or divorced —

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Feb. 3 - 1947 6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day
3 hrs. min.

9. Birthplace 1613 Rickenbacker Rd. Balto. 20
(Town, county, and state) MD.

10. Usual occupation Newborn

11. Industry or business

12. Name Patrick McMahon

13. Birthplace 1613 Rickenbacker Rd.

14. Maiden name

15. Birthplace

16. Informant Mr. Pat McMahon

Address 1613 Rickenbacker Rd.

17. Burial Date thereof Feb. 1, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Sacred Heart

Location O'Donnell St. Rd.

18. Funeral director John G. Connolly

Address 418 Eastern Ave.

19. 2-6- 19 47 John G. Connolly
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5 19 47 at 1:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 3 19 47 to Feb 5 19 47

and that I last saw him alive on Feb 4 19 47

Immediate cause of death Asphyxia

DURATION

Due to injuries (new born)

(Asphyxia, Neonatal)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

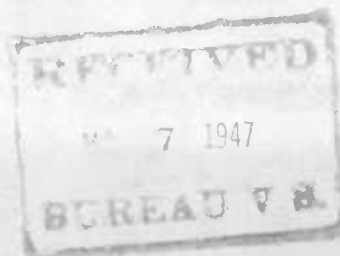
23. SIGNATURE Jack Wepler, M.D.

Address 805 Fenwick Ave. Date signed Feb 5, 47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-25

2-440 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01426

Reg. Dist. No. 321

1. PLACE OF DEATH:

County Baltimore
City or town Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 0 yrs., 0 mos., 2 days
Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium
How long in hospital or institution? 0 yrs., 0 mos., 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Baltimore City
City or town Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 616 S. Monroe St., Balto., Md.
(If rural, give LOCATION)
2. (a) If veteran, name war ✓

3. (a) FULL NAME

Leroy E. Megary

3. (b) Social Security Number

218-03-7066

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

6. (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) August 16, 1912

8. AGE: Years 34 Months 5 Days 27 If less than one day hrs. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation General Foreman

11. Industry or business

12. Name Harry Megary
13. Birthplace Baltimore, Maryland

14. Maiden name Mary D. Britton
15. Birthplace Baltimore, Maryland

16. Informant Leroy E. Megary
Address 616 S. Monroe St., Balto., Md.

17. Burial Date thereof Feb. 15, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory New Cathedral Cemetery
Location 4300 Old Fred. Rd., Balto., Md.
John J. Cowan & Son

18. Funeral director John J. Cowan & Son
Address 901-03 Hollins St., Balto., Md.

19. Feb. 12, 1947 Registrar Earl J. Webster
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 12, 1947 at 9:15 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 10, 1947 to Feb. 12, 1947 and that I last saw him alive on February 12, 1947

Immediate cause of death Pulmonary Tuberculosis

DURATION
3 yrs.
8 mos.

Due to Tubercle Bacilli

Other conditions Tuberculous Emyema

(Include pregnancy within 3 months of death)

Major findings of operations No operation

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Stewart S. Shaffer M.D. M. D. or other

Address Mount Wilson, Md. Date signed 2/12/47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Rec'd 2-15-47

RECEIVED

FEB 17 1947

BUREAU V. S.

2-25

2 - 320 — 2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate age in correct age margin reserved for binding. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01427

Reg. Dist. No. 3000

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville 28, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 47 years 7 months 22 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 47 years 7 months 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. ?
 (If rural, give LOCATION)
 2.(a) If veteran, name war ☒

3. (a) FULL NAME

Anna Meister (Roberta)

3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Henry Meister
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years 75 Months ? Days ? If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

12. Name Robert Travers

13. Birthplace Md

14. Maiden name Anna E. Neushaw

15. Birthplace Md

16. Informant Hospital Records: Ham

Address Catonsville, 28, Maryland

17. Burial Date thereof 2/22/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Balto

Location " Md.

18. Funeral director William Cook Inc.

Address 1217 St. Paul St.

19. 2/21 19 47 Ann Hedrick
 (Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 20, 1947, at 7:35 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 29, 1899 to February 20, 1947

and that I last saw her alive on February 20, 1947

Immediate cause of death Chronic myocardial insufficiency. DURATION 48 hrs.

Chronic hypertensive Cardiovascular indef.

Due to renal disease

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Isadore Tuerk, M.D. M. D. or other _____

Address Catonsville 28, Md. Date signed 2/20/47

Rec'd VS
2/21/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(46-6)

01428

CERTIFICATE OF DEATH

Reg. Dist. No. 570

1. PLACE OF DEATH:

County Baltimore
 City or town Cockeysville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 weeks
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Washington County D.C.
 City or town
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 135 Rhode Island Ave. N.E.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Horace Miller

3. (b) Social Security Number

579-18-8595

4. Sex M 5. Color or race W. 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Emma (Hoag)
 6. (c) If alive, give age 68 years
 7. Birth date of deceased (mo., day, yr.) Feb. 26, 1865
 8. AGE: Years 81 Months 11 Days 14 It less than one day
 hrs. min.

9. Birthplace Pennsylvania
 (Town, county and state)
 10. Usual occupation Printer
 11. Industry or business Times - Herald Wash, D.C.

FATHER
 12. Name Jacob Miller
 13. Birthplace Pennsylvania
 MOTHER
 14. Maiden name Frances Deats
 15. Birthplace Pennsylvania

16. Informant Mrs. George Gollsher
 Address Cockeysville, Md.

17. Funeral (Burial, cremation, or removal, Which?) Date thereof Feb. 12, 1947
 (month) (day) (year)
 Cemetery or crematory Fort Lincoln
 Location Washington, D.C.

18. Funeral director London M. Bisher
 Address Sparks, Md.

19. 2-10 47 Wilmer C. Ensor
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH Feb. 9 19 47 at 1:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 4 19 47 to Feb 9 19 47
 and that I last saw him alive on Feb 9 19 47

Immediate cause of death Chronic myocarditis

Due to
 Due to
 Other conditions Carcinoma of stomach
 (Include pregnancy within 8 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Manner of injury Injured at work?

23. SIGNATURE G. M. France M. D. or other
 Address Lakewood, Ind. Date signed 2/9/47

RECEIVED
FEB 13 1947
BUREAU OF
1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01429

Reg. Dist. No.

1. PLACE OF DEATH:

County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Peter Minczenko

3. (b) Social Security Number

4. Sex.....
 5. Color or race.....
 6. (a) Single, married, widowed, or divorced.....
 6. (b) Name of husband or wife.....
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.).....
 8. AGE: Years..... Months..... Days..... If less than one day..... hrs. min.

9. Birthplace.....
 (Town, county, and state)
 10. Usual occupation.....
 11. Industry or business.....
 12. Name.....
 13. Birthplace.....
 14. Maiden name.....
 15. Birthplace.....

16. Informant.....
 Address.....
 17. Burial.....
 (Burial, cremation, or removal, Which?).....
 Date thereof.....
 (month) (day) (year)
 Cemetery or crematory.....
 Location.....
 18. Funeral director.....
 Address.....
 19. (Date rec'd by registrar).....
 Registrar.....

MEDICAL CERTIFICATION

20. DATE OF DEATH.....
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....
 and that I last saw him alive on.....
 Immediate cause of death.....
 DURATION.....
 Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)
 Major findings of operations.....
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide.....
 Where did injury occur?.....
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury.....
 Injured at work?
 23. SIGNATURE.....
 Address.....
 Date signed.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

Reg. Dist. No.

01430

4X1

1. PLACE OF DEATH

County BaltimoreCity or town Essex
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 11 yrs.

Hospital, institution, or street address where death occurred:

344 Townsend Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Essex
(If outside city or town limits, write RURAL and give nearest town)Street No. 344 Townsend Rd.
(If rural, give LOCATION)2.(a) If veteran, name war u.s. war

3. (a) FULL NAME

Thomas Edgar Moffitt

3. (b) Social Security Number

218-01-2695A

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mary Delpha Moffitt6. (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.)

May 10, 1879

8. AGE:

Years 67 Months 9 Days 12 If less than one day
hrs. min.

9. Birthplace

Waterbury, Washington Co., Pa.
(Town, county, and state)

10. Usual occupation

Banisher

11. Industry or business

Meat produce

FATHER

12. Name John Thomas Moffitt

13. Birthplace

Washington Co., Pa.

MOTHER

14. Maiden name Mary Elizabeth Moffitt

15. Birthplace

Washington Co., Pa.

16. Informant

Mrs. Mary D. Moffitt

Address

344 Townsend Rd.

17.

(Burial, cremation, or removal. Which?) Buried Date thereof 2-25-47
(month) (day) (year)

Cemetery or crematory

Oak Lawn

Location

Balto Co

18. Funeral director

James J. Burdick

Address

4407 Eastern Ave Rd

19.

(Date rec'd by registrar) 2/24/47 D.W. Hebrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22, 1947, 2:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 22, 1947, to Feb. 22, 1947and that I last saw him alive on February 22, 1947

Immediate cause of death

Coronary Occlusion

DURATION

4 hrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Myocardial infarction Injured at work?

23. SIGNATURE

Joseph Miceli M.D. M. D. or otherAddress 760 Eastern Ave Date signed 2/22/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 68 days
 Hospital, institution, or street address where death occurred:
Veterans Adm. Hospital
 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 118 S. Caroline St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war WW-1

3. (a) FULL NAME

MONDOWNEY, Raymond C.

3. (b) Social Security Number

unknown

4. Sex Male 5. Color or race Col. 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife Single

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) 1-1-1895

8. AGE: Years 52 Months 1 Days 22 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)10. Usual occupation Unemployed

11. Industry or business

FATHER 12. Name Gerald Mondowney
 13. Birthplace Virginia

MOTHER 14. Maiden name Elizabeth Armstrong
 15. Birthplace Maryland

16. Informant V1 Clinical Records, Vets. Adm. Hosp.
 Address Fort Howard, Maryland

17. Burial Date thereof 2/26/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Baltimore National Cemetery
 Location 5501 Frederick Ave. Balto. Md.

18. Funeral director Charles R. Law
 Address 802 Madison Ave. Balto. Md.

19. 2/25 47 R. W. Hedrick
 (Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 23 19 47 at 3:20 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from December 16 19 47 to February 23 19 47
 and that I last saw him alive on February 23 19 47

Immediate cause of death Invasion of superior vena cava with squamous cell carcinoma. Thrombosis of superior vena cava. Carcinoma originated in bronchial rest in right mediastinum
 DURATION 12-16-46
plus

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations Hemorrhoidectomy; Bronchoscopic Examination
 Date of op. _____

Autopsy results Substantiated as above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE R. M. Cullison
R. M. CULLISON, M.D.
CLIN. DIR. M. D. or other _____
 Address VAH, FT. HOWARD, MD. Date signed 2-24-47

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

1. PLACE OF DEATH

County

Baltimore

Village or City

Sparrows Point

Registration Dist. No.

410

No.

412 C. St.

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U.S. if of foreign birth?

yrs.

mos.

ds.

2. FULL NAME

Edward F. Moriarty

(a) Residence: No.

412 C. St.

St.

Ward.

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

*Divorced*5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of*Ellen Webb*

6. DATE OF BIRTH (month, day, and year)

Aug 4/1895

7. AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

*51**6**24*

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

R. R.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

B. & O. Co.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town)

(State or country)

Ireland

FATHER

13. NAME

James J. Moriarty

14. BIRTHPLACE (city or town)

(State or country)

Ireland

15. MAIDEN NAME

Bridget Brennan

16. BIRTHPLACE (city or town)

(State or country)

Ireland

17. INFORMANT

(Address)

*Thomas L. Moriarty
2 Grace Court, Brooklyn, N.Y.*

18. BURIAL, CREMATION, OR REMOVAL

Place

Williamson, Conn. Date Feb. 28, 1947

19. UNDERTAKER

(Address)

*Roland L. Fisher
2112 Dunsalk Ave.*

20. FILED

*2/28/47**1947*

Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

Feb 28/47
(Month) (Day) (Year)

22.

I HEREBY CERTIFY, That I attended deceased from
Feb 28, 1947, to *Feb 28, 1947*, 19I last saw him alive on *Feb 28, 1947*, 19to have occurred on the date stated above, at *Feb 28, 1947*, m.

The PRINCIPAL CAUSE OF DEATH and related causes of Importance were as follows:

Coronary occlusion

Date of onset

Other Contributory Causes of importance:

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide?

Date of injury

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

(Address)

*Deputy Medical Examiner
Baltimore, Md.*

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>
Other contributory causes of importance:	
<i>Gallstones</i>	<i>May 1, 1923</i>

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>
Other contributory causes of importance:	
<i>Gastroenteritis</i>	<i>1 year</i>

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01433

Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 108 days
 Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland
 How long in hospital or institution? 108 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 214 N. Chester St.,
 (If rural, give LOCATION)
 2. (a) If veteran, name war WW II

3. (a) FULL NAME

EDWARD T. MOTTER

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Anne Motter
 6. (c) If alive, give age 29 years
 7. Birth date of deceased (mo., day, yr.) 12-18-16
 8. AGE: Years 30 Months 2 Days 9 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Maryland
 (Town, county, and state)
 10. Usual occupation Real Estate
 11. Industry or business _____
 FATHER
 12. Name Isaac Motter
 13. Birthplace Maryland
 MOTHER
 14. Maiden name Dona Frizzell
 15. Birthplace Maryland

16. Informant Clinical Records, Vets. Adm. Hosp.
 Address Fort Howard, Maryland
 17. Burial Date thereof Mar 3-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Moreland Memorial Cemetery
 Location Baltimore, Md.
 18. Funeral director Ullrich Funeral Home
 Address 2004-08 Orleans St., Balto., Md.
 19. 2/28 47 A.W. Hedrick
 (Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 27 19 47 at 6:00 Pm
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 11 19 47 to February 27 19 47
 and that I last saw him alive on February 27 19 47
 Immediate cause of death FIBROSARCOMA WITH METASTASIS TO LIVER, ORIGIN UNDETERMINED
 DURATION 6 months plus

Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Ronald J. Lashin, M.D. M. D. or other _____
 Address VAH, Ft. Howard, Md. Date signed 2-27-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. P01434
950
330

1. PLACE OF DEATH:

County..... Baltimore
City or town..... Owings Mills
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Baltimore
City or town..... Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
Street No. Church Road
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Andrew Pape

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Jan 8, 1874 6. (c) If alive, give age..... years

8. AGE: Years 73 Months 0 Days 8 It less than one day..... hrs. min.

9. Birthplace..... Baltimore Maryland
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name..... Henry A. Pape13. Birthplace..... Germany14. Maiden name..... Elizabeth Knell15. Birthplace..... Baltimore Maryland16. Informant..... Phillip L. PapeAddress..... Butter Lane, Owings Mills17. Burial..... Burial Date thereof..... 2-19-47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... New Catholic CemeteryLocation..... Baltimore Maryland18. Funeral director..... Loring, PhilipAddress..... 5705 York & Lehigh Ave19. 2/18 47 H. W. Hedzuel Registrar

(Date rec'd by registrar) 19.....

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16 19 47, at 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-17-47 19..... to 2-17-47 19.....
and that I last saw him im alive on not seen alive 19.....

Immediate cause of death.....
Acute Cardiac Decompensation
Bronchitis

DURATION

6 hrs.
1 wk.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

NONE Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? NONE (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... D. D. Copius, M.D. examined

M. D. or other

Address..... Reisterstown, Md. Date signed 2-17-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (182)

CERTIFICATE OF DEATH

Reg. Dist. No. 387

1. PLACE OF DEATH:

County BaltimoreCity or town Towson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltimoreCity or town Towson
(If outside city or town limits, write RURAL and give nearest town)Street No. 1657 Yakoma Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William Douglas Parrish

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced child

8.(b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.) June 19-1946

6.(c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

85

hrs.

min.

9. Birthplace

Baltimore City

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

A. Stanley Parrish

13. Birthplace

Baltimore City

14. Maiden name

Barbara A. Van

15. Birthplace

Missouri

16. Informant

Mr. A. Stanley Parrish

Address

1657 Yakoma Ave. Towson

17.

(Burial, cremation, or removal. Which?) Burial

Date thereof

Feb 26-47
(month) (day) (year)

Cemetery or crematory

Wood Ridge

Location

Baltimore Md.

18. Funeral director

Frank H. Seitz

Address

814 N. 36 St. Baltimore

19.

(Date read by registrar)

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MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24 1947 at 10:00 AM MD

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.

19.

and that I last saw him alive on 19.

Immediate cause of death

DURATION

Suffocation (accidental) Sudden

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of Feb 24-47

Where did injury occur?

TOWSON-4-BALTIMORE MD

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) Home

Means of injury

Injured at work?

Suffocated in crib (overhead)

23. SIGNATURE

John X. Green

M.D. or other

Address

Towson-4-Baltimore

Date signed

Feb 24-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of day of death is shown on form 4109-3/26/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-2)

CERTIFICATE OF DEATH

01436

Reg. Dist. No. 3d1

1. PLACE OF DEATH:

County BaltimoreCity or town Catonville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs.

Hospital, institution, or street address where death occurred

How long in hospital or institution?

3. (a) FULL NAME

Charles Leland Poisal4. Sex Male5. Color or race White6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Mary C. Poisal6. (c) If alive, give age 72 years7. Birth date of deceased (mo., day, yr.) February 9, 18718. AGE: Years 76 Months — Days 2 If less than one day

hrs. min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual occupation Railroad Worker11. Industry or business Retired12. Name John Poisal13. Birthplace Maryland14. Maiden name Isabelle Bolley15. Birthplace Virginia16. Informant Anna May CaulkAddress Frederick Rd. + N. Rolling Rd.17. Burial Date thereof Feb. 14, 1947

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. Ann's CathedralLocation Baltimore, Maryland18. Funeral director George L. SchwalbAddress 21014 Melnick Avenue19. 2-13 1947 Garry H. Miller

(Date rec'd by registrar) (Signature of Registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Catonville

(If outside city or town limits, write RURAL and give nearest town)

Street No. Frederick Rd. + N. Rolling Road

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH February 8, 1947 at 9:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 14, 1943 to February 8, 1947and that I last saw him alive on February 8, 1947Immediate cause of death Myocardial DecompensationDURATION 2 mo.Due to Chs. Tabular Myocarditis 15 yr.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William K. Gallager, M.D.Address Catonville-28, Md. Date signed 2-12-47

M. D. or other

RECEIVED

FEB 15 1947

BUREAU V. A.

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

01437

370

1. PLACE OF DEATH:

County Baltimore
City or town Parkville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Baltimore
City or town Parkville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 8610 Old Harford Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Emanuele Provenzano

3. (b) Social Security Number

216-05-0249

4. Sex male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Concetta

7. Birth date of deceased (mo., day, yr.) June 20 1894
6. (c) If alive, give age..... years

8. AGE: Years 52 Months 7 Days 26 If less than one day
..... hrs. min.

9. Birthplace Valguarnera Caropepe Italy
(Town, county, and state)

10. Usual occupation Coat Presser11. Industry or business Coat Shop of F.F.Tailoring Co.12. Name Cristofero Provenzano13. Birthplace Italy14. Maiden name Concetta15. Birthplace Italy16. Informant Cristopher Provenzano

Address 8610 Old Harford Rd.

17. Burial Date thereof Feb. 19 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetary or crematory Holy RedeemerLocation Belair Rd. Baltimore Md.18. Funeral director Frank Della VoeAddress 52 N. Morley St.

19. 2/17 47 A. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15 19 47 at 5:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2/15 19 47 to 2/15 19 47
and that I last saw him alive on 2/15 19 47

Immediate cause of death

DURATION

Coronary thrombosis 15 Min.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Harold E. Grott, M.D.

M. D. or other

Address 8600 Harford Rd. Date signed 2/16/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 400

1. PLACE OF DEATH:

County Ba Sto
 City or town Bradshaw
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 mo.
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Ba Sto
 City or town Bradshaw Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. St Stephens church
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Rev. Fr. George M. Rankin

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife _____
 7. Birth date of deceased (mo., day, yr.) May 8 - 1900
 8. AGE: Years 46 Months 9 Days 13 It less than one day _____ hrs. _____ min.
 8.(c) If alive, give age _____ years

9. Birthplace New York City N.Y.
 (Town, county, and state)
 10. Usual occupation Catholic Priest
 11. Industry or business _____

FATHER 12. Name David Rankin
 13. Birthplace Ireland
 MOTHER 14. Maiden name Mary Whalen
 15. Birthplace Ireland

16. Informant Christina McNicks
 Address 1335 Underwood St. N.W. 12

17. Burial Washington D.C.
 (Burial, cremation, or removal. Which?) Date thereof 26 Feb 47
 (month) (day) (year)
 Cemetery or crematory Mt. Olivet
 Location Washington D.C.

18. Funeral director Martin A. E. Wiegand's Sons
 Address 7110 Belair Rd

19. 2/24 47 St. Stephens church
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 February 19 47, at 9 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 February 19 47 to 22 Feb 19 47
 and that I last saw him alive on 22 Feb. 19 47

Immediate cause of death Cerebral Hemorrhage DURATION 1 hr

Due to Hypertensive
Cardio-Vascular disease 10 yrs

Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE L. Edwin Muller
2 W. Read St - Ba Sto M. D. 22 Feb 47
 Address _____ Date signed _____

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 158

CERTIFICATE OF DEATH

01439

Reg. Dist. No.

410

1. PLACE OF DEATH:

County BaltimoreCity or town Turner Station
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Turner Station
(If outside city or town limits, write RURAL and give nearest town)Street No. 118 East ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Samuel Richburg

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Colored

6.(a) Single, married, widowed, or divorced

Single

8.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

August 25, 1946

8. AGE:

Years

Months

Days

If less than one day

514

hrs.

min.

9. Birthplace

Baltimore City Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date

M. D. or other

2/10/47

MARGIN RESERVED FOR BINDING

VS A15-9-45-1-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 12 1947

BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the charge of

Age is shown on g 109-

3/6/49

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Bd

CERTIFICATE OF DEATH

01440



Reg. Dist. No. 301

1. PLACE OF DEATH:

County... Baltimore Co
 City or town... Catonville Md
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

60 yrs.
 Hospital, institution, or street address where death occurred: aged Home Gallatien

How long in hospital or institution?

2 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Baltimore

City or town... Catonville
 (If outside city or town limits, write RURAL and give nearest town)

Street No... State Ave
 (If rural, give LOCATION)

2.(a) If veteran, same war

3. (a) FULL NAME

Mary Stafford Roache

3. (b) Social Security Number

4. Sex... F 5. Color or race... In 6.(a) Single, married, widowed, or divorced... widowed

6.(b) Name of husband or wife... Thomas Roache

7. Birth date of deceased (mo., day, yr.)... May 11 1866
 8. (c) If alive, give age... years

8. AGE: Years... 80 Months... Days... If less than one day... hrs. min.

9. Birthplace... Wexford - Ireland
 (Town, county, and state)

10. Usual occupation... Domestic11. Industry or business... House12. Name... Joseph Stafford13. Birthplace... Wexford - Ireland14. Maiden name... Ann Cassidy15. Birthplace... Wexford - Ireland16. Informant... John F Roache

Address... Feels are Ellicott City
Buial Date thereof... 2/23/49

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... New Cathedral

Location... Baeto City

18. Funeral director... John S. Mar 948

Address... Catonville Md

19. 2-21- 19 47 Harold W. Miller Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH... February 19 1947, at P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 19 46, to Feb 19 19 47

and that I last saw him alive on Feb 19 19 47

Immediate cause of death... Arteriosclerotic Cardio-vascular disease

Due to... Arteriosclerotic Cardio-vascular disease

Due to... Arteriosclerotic Cardio-vascular disease

Other conditions... Arteriosclerotic Cardio-vascular disease

(Include pregnancy within 3 months of death)

Major findings of operations... Arteriosclerotic Cardio-vascular disease

Antopsy results... Arteriosclerotic Cardio-vascular disease

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of... 2/23/49

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Harold W. Miller M. D. or other

Address... Ellicott City Md Date signed... 2/23/49

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

RECEIVED

SEP 24 1947

ST. HEAL V B.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01441

Reg. Dist. No. 300

1. PLACE OF DEATH:

County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs., 6 mos., 14 days
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 3 yrs., 6 mos., 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 20 E. Mt. Vernon Place
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Ella Paige Robinson

3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife Samuel C. Robinson
6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) June 20, 1860? 1861? 1859

8. AGE: Years 87 Months 08 Days - If less than one day _____ hrs. _____ min.

9. Birthplace Virginia (Lynchburg)
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

FATHER 12. Name ? Burton

13. Birthplace Georgia

MOTHER 14. Maiden name Ella ?

15. Birthplace Virginia

16. Informant Hospital records

Address Catonsville-28, Maryland

17. Burial Burial Date thereof 2/22/47
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Woodlawn

Location " Md

18. Funeral director William Cook Inc.

Address 1217 St. Paul et Balto 2 Md

19. 2/21 AW Hedrick Registrar
(Date rec'd by registrar) 1-3-47

MEDICAL CERTIFICATION

20. DATE OF DEATH February 20 19 47 at 10:20am

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 6 19 43 to February 20 19 47

and that I last saw her alive on February 20 19 47

Immediate cause of death Chronic myocarditis DURATION Indefinite

Due to Generalized arteriosclerosis "

Due to Chronic interstitial nephritis "

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

Signature Isadore Tuerk, M.D.

23. SIGNATURE _____ M. D. or other _____

Address Catonsville-28, Md Date signed 2-20-47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Rec'd VS
2/21/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

Reg. Dist. No.

01442

330

1. PLACE OF DEATH:

County Baltimore
 City or town Cumms Mills, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 9 yrs 3 mos 8 days
 Hospital, institution, or street address where death occurred:
Cumms Mills, Md.
 How long in hospital or institution? 9 yrs 3 mos 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1218 Bell St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war ✓

3. (a) FULL NAME

Shedden Joseph Ralle

3. (b) Social Security Number

4. Sex m 5. Color of race w 6. (a) Single, married, widowed, or divorced S.

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Feb 16, 1931

8. AGE: Years 16 Months 0 Days 11 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Md.
 (Town, county, and state)

10. Usual occupation Student, Reswood State

11. Industry or business Training School Cumms Mills, Md.

12. Name Frank W. Ralle

13. Birthplace Baltimore, Md.

14. Maiden name Dora C. Becker

15. Birthplace Baltimore, Md.

16. Informant Institutional records -

Address Cumms Mills, Md.

17. Burial - Date thereof March 3, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Italy Cross Cem.

Location A. G. Co., Md.

18. Funeral director D. Howard Evans

Address 1400 Charles St. Balto. 39, Md.

19. 3/1 19 47 9. H. Gedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Feb 19 47 at 1:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 25 Feb 19 47 to 27 Feb 19 47
 and that I last saw him alive on 27 Feb 19 47

Immediate cause of death _____ DURATION _____

Broncho-Pneumonia 3 days
 Due to Acute Bronchitis 7 "

Due to missed upstake infection with
gastroenteritis and S. flex.

Other conditions partial Epilepsy

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE H. B. Ruppel M. D. or other _____

Address Cumms Mills, Md. Date signed 27 Feb 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Bd)

CERTIFICATE OF DEATH

Reg. Dist. No. 01443 300

1. PLACE OF DEATH: Baltimore
 County.....
 City or town..... Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
Franklin & Ingleside Aves.
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Md. County..... Baltimore
 City or town..... Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Franklin & Ingleside Ave.
 (If rural, give LOCATION)
 2. (a) If veteran, name war.....

3. (a) FULL NAME MARY BROOKE ROSE 3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced widow

6. (b) Name of husband or wife Thomas P. Rose

6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) March 1, 1870

8. AGE: Years 76 Months 11 Days 24 If less than one day
 hrs. min.

9. Birthplace Baltimore
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Wm. Henry Truehart

13. Birthplace Richmond, Va.

MOTHER 14. Maiden name Lucie Ann White

15. Birthplace Richmond, Va.

16. Informant Mr. T. Duncan Rose

Address 2908 Poplar Terr.

17. Burial Date thereof 2/28/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Woodlawn Cem.

Location Woodlawn, Md.

18. Funeral director WM. J. TICKNER & SONS

Address Balto., Md.

19. 5/27 47 Dr. Hadriat
 (Date rec'd by registrar) 19-35 Registrar

MEDICAL CERTIFICATION
February 25, 47 6:10 p M
 20. DATE OF DEATH..... 19..... at.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Feb 5-1947 to Feb 25-1947
 and that I last saw him alive on Feb 24 19.....

Immediate cause of death.....
Chronic Myocarditis;
acute dilatation of heart
 Due to..... Age

DURATION 30 days
 Due to.....
 Other conditions.....
 (Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE..... A. C. Samuel M. D. or other
 Address..... 4519 Liberty Date signed Feb 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 years, 3 mos., 22 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 4 years, 3 mos., 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Sparrows Point - Edgemere
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Marine Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

James Lee Rumble

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Sarah Ann George
 6.(c) If alive, give age 61 years
 7. Birth date of deceased (mo., day, yr.) September 5, 1871
 8. AGE: Years 75 Months 5 Days 20 If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
 (Town, county, and state)
 10. Usual occupation Machinist
 11. Industry or business Factory
 12. Name Shadrick Rumble
 13. Birthplace Ireland
 14. Maiden name Hester Porter
 15. Birthplace Maryland

16. Informant Hospital records
 Address Catonsville-28, Maryland
 17. Burial Date thereof Feb 28/47
 (Burial, cremation, or removal. Which) (month) (day) (year)
 Cemetery or crematory Baldwin
 Location Philips Perdigons
 18. Funeral director 2024 Orleans St
 Address 127 87
 19. (Date rec'd by registrar) _____ Registrar Isadore Tuerk

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25 19 47 at 8:25 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 3 19 42 to February 25 19 47
 and that I last saw him alive on February 25 19 47

Immediate cause of death Lobar pneumonia
 DURATION 24 hrs.

Due to Gangrene (arteriosclerotic) 2 weeks

Due to Arteriosclerotic cardiovascular-renal disease indefinite

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results..... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Isadore Tuerk, M.D. M. D. or otherAddress Catonsville-28, Md. Date signed 2-25-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01445

1. PLACE OF DEATH:
 County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
315 Ingleside Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
Ma. County County
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 315 Ingleside Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Ann R. Sandler

3. (b) Social Security Number

4. Sex Female 5. Color or race W. 6.(a) Single, married, widowed, or divorced Widow
 6.(b) Name of husband or wife Late Henry L. Sandler
 7. Birth date of deceased (mo., day, yr.) Sept. 24, 1876 6.(c) If alive, give age _____ years
 8. AGE: Years 70 Months 4 Days 26 If less than one day _____ hrs. _____ min.

9. Birthplace Ma. (Town, county, and state)
 10. Usual occupation None
 11. Industry or business
 12. Name Unknown
 13. Birthplace Unknown
 14. Maiden name Unknown
 15. Birthplace Unknown

16. Informant Mr. P. August Grill
 Address 613 Rosedale St.

17. Burial Burial Date thereof Feb. 22/47.
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Loudon Park
 Location 3801 Frederick Rd.
 18. Funeral director Harry H. Hutzke
 Address 4101 Edmondson Ave.
 19. 2/22 19 47 A. R. Hensch
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 19, 1947 at 11 P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1, 1944 to February 16, 1947
 and that I last saw him alive on February 9, 1947
 Immediate cause of death Coronary atherosclerosis
 Due to hypertension that strain
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

DURATION

5 days -

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?
 23. SIGNATURE John P. Kuchner M. D. or other
 Address Ellicott City Date signed 2/22/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01446

Reg. Dist. No. 440

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 70 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Fort Howard, MarylandHow long in hospital or institution? 70 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 1026 Stoddard Court, McCulloch Homes
(If rural, give LOCATION)2(a) If veteran, name war WW-2

3. (a) FULL NAME

ELMER W. SCHAIRED

3. (b) Social Security Number

212-16-0910

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Single6. (b) Name of husband or wife Single

7. Birth date of deceased (mo., day, yr.)

12-8-1916

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

3022

hrs.

min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual occupation Truck Driver

11. Industry or business

FATHER

12. Name

William Schaired

13. Birthplace

Virginia

MOTHER

14. Maiden name

Emma Jones

15. Birthplace

Maryland16. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Maryland

17.

(Burial, cremation, or removal, Which?)

Date thereof

2-13-47
(month) (day) (year)

Cemetery or crematory

Balt. National Cem.

Location

Frederick Ave.

18. Funeral director

Charles R. Lew

Address

807 Madison Ave.2-12-47A W Hedrich L

19. (Date rec'd by registrar)

19

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 10, 19 47 at 6:13 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 2, 19 47, to February 10, 19 47and that I last saw him alive on February 10, 19 47Immediate cause of death Hypertensive Heart Disease with extreme hypertrophy and 8 mos. dilatation of ventricles and heart plus failure.

DURATION

Due to

Other conditions Pulmonary infarctionRight hydrothorax

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert M. Cullison
R.M. CULLISON, M.D. CLIN. DIR.Address V.A. FT. HOWARD, MD. Date signed 2-10-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

Reg. Dist. No. 01447 30

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 years, 11 months, 5 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 3 years, 11 months, 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1113 South Robinson Street
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Sarah Schissler

3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife Jake Schissler

7. Birth date of deceased (mo., day, yr.) August 22, 1868
 6. (c) If alive, give age _____ years

8. AGE: Years 78 Months 6 Days 3 If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
 (Town, county, and state)

10. Usual occupation Housewife11. Industry or business Home12. Name David Ketchum13. Birthplace Maryland14. Maiden name Martha Smith15. Birthplace Maryland16. Informant Hospital recordsAddress Catonsville-28, Maryland

17. Burial Date thereat 2-28-1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Oak LawnLocation Eastern Ave.18. Funeral director Steffy & Zeiler, Inc.Address 403 S. Wolfe St. zone 31

19. Feb. 27 19 47 A. W. Peduski
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25 19 47, at 4:50 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on 19Immediate cause of death Forsema DURATIONDue to Lobar Pneumonia

Due to _____

Other conditions Sudden death(Include pregnancy within 3 months of death) Inquiry

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of Feb 10, 45Where did injury occur? Catonsville Baltimore (City or town) (County) (State)Injured at home, farm, industry, public place (where?) hospitalMeans of injury gun or right arm Injured at work? no23. SIGNATURE Geo. L. McKieffer, Jr. M. D. or otherAddress 1610 Hudson Date signed 2-25-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 44

01448

1. PLACE OF DEATH:

County Balto
 City or town Essex
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

311 Montrose Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County Balto

City or town Essex
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 311 Montrose Ave.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

John G. Schoberlein

3. (b) Social Security Number

4. Sex

M

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Mary Eliz (Frederick)

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Feb 5th 1864

8. AGE:

Years

Months

Days

If less than one day

82

hrs.

min.

9. Birthplace

Balto Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

Conrad Schoberlein

13. Birthplace

Germany

14. Maiden name

York

15. Birthplace

Germany

16. Informant

Mrs Eliz Bushman

Address

311 Montrose Ave.

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

2-7-47
(month) (day) (year)

Cemetery or crematory

St. Connel

Location

O Connell St Rd

18. Funeral director

John G. Connolly

Address

418 Eastern Ave.

19.

2/6/
(Date rec'd by registrar)

19.

47John G. Connolly
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7 19 47 at 12 noon M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1 19 47, to Feb 4 19 47and that I last saw him alive on Feb 4 19 47

Immediate cause of death

Thrombosis

DURATION

Sudden

Due to

Arterio-Sclerotic
Cardio-Vasculardisease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Ed M. Baumgardner
M. D. or other
Address Balto 6 Date signed 2-8-47

RECEIVED
FEB 10 1947
BUREAU V.B.

RECEIVED
FEB 11 1947
BUREAU V.B.

1-25

2-440

1-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 7462

CERTIFICATE OF DEATH

01449

Reg. Dist. No. 3220

1. PLACE OF DEATH:

County Baltimore
 City or town Pikesville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 45 yrs.
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Pikesville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 206 Oak Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Arthur Alfred Shipley

3. (b) Social Security Number

213-01-7600

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed or divorced Married
 8. (b) Name of husband or wife Mina E. Shipley
 6. (c) If alive, give age 61 years
 7. Birth date of deceased (mo., day, yr.) July 5, 1882
 8. AGE: Years 64 Months 7 Days 11 If less than one day _____ hrs. _____ min.

9. Birthplace Pikesville, Maryland
 (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business Faste leg

12. Name Dallas W. Shipley

13. Birthplace Carroll Co. Maryland

14. Maiden name Cecilia E. G. Smith

15. Birthplace Gambler, Carroll Co. Md.

16. Informant Mina E. Shipley

Address 206 Oak Ave. Pikesville, Md.

17. Burial Date thereof 2/18/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Daniel Ridge

Location Pikesville, Maryland

18. Funeral director Frank H. Newell

Address Pikesville, Maryland

19. 2-18- 19 47 Dr. E. E. Nichols
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH Feb 16 19 47, at 8:40 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 17 19 47, to Feb 17 19 47, and that I last saw him live on Feb 17 19 47.

Immediate cause of death Coronary Occlusion DURATION 5 min.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations None

Antopsy results None Date of op. _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE D. D. Caples, M. D. med exam
 M. D. or other

Address Riverton, Ind. Date signed 2-17-47

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

¹⁹
FEB ~~X~~ 1947

BUREAU 1 &

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 946

CERTIFICATE OF DEATH

01450 370
Reg. Dist. No.

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Cockeysville P.O. - Jessas Road
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... Lifetime
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Baltimore
 City or town..... Jessas - Cockeysville P.O. Road
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... York Road
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

William F. Shoul

3. (b) Social Security Number

214-03-7795

4. Sex

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Elsie M. (nee Marble)

7. Birth date of

deceased (mo., day, yr.)

Oct. 12, 18826. (c) If alive, give age..... 64 years

8. AGE:

Years

Months

Days

If less than one day

64411

..... hrs. min.

9. Birthplace.....

Balto. Co. Md.

(Town, county, and state)

10. Usual occupation.....

Asst. Foreman - Motor Div.

11. Industry or business

Balto. Transit Co.

FATHER

12. Name.....

Henry Shoul

13. Birthplace

Maryland

MOTHER

14. Maiden name.....

Anna Louise Davis

15. Birthplace

Maryland

16. Informant.....

Mrs. Wm. F. Shoul

Address

Cockeysville, Md.

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof.....

Feb. 26, 1947

Cemetery or crematory.....

St. Joseph's

Location.....

Jessas, Md.

18. Funeral director.....

Sandra M. Brooks

Address

Baltimore, Md.

19. Date rec'd by registrar

2-24

19. 47

Wilmer C. Ensor

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

February 23

1947, at.....

2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 25

1943, to

January 25

1947

and that I last saw him alive on

January 25

1947

Immediate cause of death.....

Angina Pectoris

DURATION

?

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

T. N. de Guerezo

Injured at work?

23. SIGNATURE.....

J. H. de Guerezo, M.D.

M. D. or other

Address.....

Box 6967, Town 4, RDDate signed 3/23/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 26 1947

BUREAU V.B.

1-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 370

1. PLACE OF DEATH:

County Baltimore
 City or town Monkton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 26 years
 Hospital, institution, or street address where death occurred:
Irish Ave.
 How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Monkton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Irish Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war No

3. (a) FULL NAME

William Alexander Richard

3. (b) Social Security Number

-

4. Sex Male 5. Color of race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Anna Bankert Richard
 6. (c) If alive, give age 70 years
 7. Birth date of deceased (mo., day, yr.) March 13, 1876
 8. AGE: Years 70 Months 10 Days 19 If less than one day
hrs. min.

8. Birthplace Germany
(Town, county, and state)10. Usual occupation Farm11. Industry or business Own farm12. Name William Richard13. Birthplace Germany14. Maiden name Not known15. Birthplace Germany16. Informant Herman Paul Richard (son)Address Monkton, Md.17. Burial Date thereof 2/5/47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Western Cem.Location Balto., Md.18. Funeral director WM. J. TICKNER & SONSAddress Balto., Md.19. 2-3 47 Accepted
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2 19 47, at 7 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 19, to 19 19and that I last saw him alive on 19 19Immediate cause of death Heart disease, coronary occlusion Sudden

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature Rollin C. Hudson M.D. D.M.E.Address Towson Md. Date signed 2/2/47

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT COPY. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

01452

1. PLACE OF DEATH

County BaltimoreVillage or City Jurassic StationRegistration Dist. No. 410No. Bear Creek St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U.S. if of foreign birth? _____ yrs. _____ mos. _____ ds.

2. FULL NAME

(a) Residence: No. 201 Morton Court Ward _____

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

Colored5. SINGLE, MARRIED, WIDOWED,
OR DIVORCED (write the word)Single5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, and year)

July 17/1940

7. AGE

Years

6

Months

6

Days

20

If LESS than

1 day, _____ hrs.
or _____ min.

OCCUPATION

8. Trade, profession, or particular
kind of work done, as SPINNER,
SAWYER, BOOKKEEPER, etc.School9. Industry or business in which
work was done, as SILK MILL,
SAW MILL, BANK, etc.10. Date deceased last worked at
this occupation (month and
year)11. Total time (years)
spent in this
occupation12. BIRTHPLACE (city or town)
(State or country)Pittsboro N.C.

FATHER

13. NAME

McCoy Selmer14. BIRTHPLACE (city or town)
(State or country)Pittsboro N.C.

MOTHER

15. MAIDEN NAME

Ethel Howard16. BIRTHPLACE (city or town)
(State or country)Pittsboro N.C.

17. INFORMANT

(Address)

McCoy Selmer
201 Morton Court

18. BURIAL, CREMATION, OR REMOVAL

Place

MT Calvary Date 2/11/47

19. UNDERTAKER

(Address)

Eloy D. Johnson
1000 Beantley

20. FILED

2/9/47 W. M. Mearns
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

July 6 1947
(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____

I last saw him _____ alive on _____, 19____; death is said

to have occurred on the date stated above, at 9 A. m.The PRINCIPAL CAUSE OF DEATH and related causes of Importance
were as follows:Accidental Drowning
Fell through ice.

Date of onset

Other Contributory Causes of importance:

Body found 2/7/47.

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

(Address)

W. Mearns M. D.
Deputy Medical Examiner

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>
Other contributory causes of importance:	
<i>Gallstones</i>	<i>May 1, 1923</i>

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>
Other contributory causes of importance:	
<i>Gastroenteritis</i>	<i>1 year</i>

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01453

Reg. Dist. No. 351

1. PLACE OF DEATH:

County Baltimore
 City or town Rural near Parkton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 53 yrs.
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Rural near Parkton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 3 mi. North of Parkton
 (If rural, give LOCATION)
 2(a) If veteran, name war _____

3. (a) FULL NAME

Blanche Delilah Simpson

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Lawrence J. Simpson7. Birth date of deceased (mo., day, yr.) April 29, 1893 6. (c) If alive, give age 55 years8. AGE: Years 53 Months 9 Days 22 If less than one day _____ hrs. _____ min.9. Birthplace Parkton, Md. R.D.
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own home12. Name John Noah Hunt13. Birthplace Maryland14. Maiden name Emma Irene Wilson15. Birthplace Maryland16. Informant Lawrence J. SimpsonAddress Parkton, Md. R.D.17. Buried Date thereof Feb. 24, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory New MarketLocation Maryland Line, Md.18. Funeral director Isaac HartmanAddress New Freedom, Pa.19. Feb. 23 1947 Charles L. Fisher
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 21, 1947, at 11:45 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. -15- 1947 to Feb. 21- 1947 and that I last saw her alive on Feb. 20- 1947Immediate cause of death Myocardial StenosisDue to diabetes mellitus

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE James Lyagle M. D. or other _____
Address New Freedom, Pa. Date signed 2/22-47

RECEIVED

MAR 5 1947

BUREAU V. B.

2-25

2-350-1-1000

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 01159

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 7916 Oakdale Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore.

(c) City or town
(If outside city or town limits, write RURAL and give town)

(d) Street No. 7916 Oakdale Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

Harry B. Smith.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife Elizabeth Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 23rd. 1890

8. AGE: Years

57

Months

Days

13

If less than one day

hr.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual Occupation

Metal Worker

11. Industry or business

FATHER

12. Name

Peter Smith.

13. Birthplace

Md.

MOTHER

14. Maiden Name

Katherine Dorsey.

15. Birthplace

Md.

16 (a) Informant

Elizabeth Smith

(b) Address

7916 Oakdale Ave

17 (a)

Burial

(b) Date thereof

Feb. 10 th

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Holy Redeemer Cem.

Location

Geo. M. Fink & Son.

811. N. Wolfe St.

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7th. 1947, at 1/30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1. 1946 to Feb 7. 1947, and that I last saw him alive on Feb 6. 1947.

Immediate cause of death

Coronary Insufficiency

Duration

1 wk.

Due to

arteriosclerotic heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

George S. Davis

Address

4308 Harford Rd.

Date signed 2/8/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0145441

1. PLACE OF DEATH:

County BaltoCity or town Essex Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County BaltoCity or town Essex
(If outside city or town limits, write RURAL and give nearest town)Street No. 1 Goshall Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Marie Barbara Smith

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Wm. E.

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Feb. 6 - 1901

8. AGE:

Years 46Months 0Days 5

If less than one day

.....hrs.min.

9. Birthplace

Balto Md
(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

MOTHER

12. Name

Wm. Koch

13. Birthplace

Germany

14. Maiden name

Elizabeth Schott

15. Birthplace

Md

16. Informant

Wm. E. Smith

Address

1 Goshall Ave - Essex

17.

(Burial, cremation, or removal. Which?)

Date thereof

2-14-47
(month) (day) (year)

Cemetery or crematory

St. John

Location

Balto Co

18. Funeral director

James H. Bredin

Address

1407 Eastern Ave Rd.

19.

2-13-47
(Date rec'd by registrar)47Registrar

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 19 47 at 1:50 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 19 46 to Feb 11 - 19 47and that I last saw him/her alive on Feb 11 - 19 47

Immediate cause of death

DURATION

Carcinoma of breast

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Agnes Zeller, M.D.
M. D. or otherAddress 2739 Eastern Ave Date signed 2/13/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hr

min.

9. Birthplace

(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

(b)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

19

at

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature

Medical Examiner

M.D.

Date signed

FEB 15

1947

Huntington, West Virginia, M.D.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B-1

CERTIFICATE OF DEATH

01456

Reg. Dist. No. 420

1. PLACE OF DEATH:

County Balto.

City or town Londontown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred Home Lane

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Balto. Md. County Balto.

City or town Londontown
(If outside city or town limits, write RURAL and give nearest town)

Street No. Flower Lane
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Alto Christian Stebbins

3.(b) Social Security Number

217-18-3246

4. Sex Male

5. Color or race W.

6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife not known

7. Birth date of deceased (mo., day, yr.) not known 1887
6.(c) If alive, give age _____ years

8. AGE: Years about 60 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Germany
(Town, county, and state)

10. Usual occupation none

11. Industry or business Christian Stebbins

12. Name Christian Stebbins

13. Birthplace not known

14. Maiden name unknown

15. Birthplace not known

16. Informant Daughter Maria Christ

Address 2237 Guilford Ave

17. Burial Date thereof Feb 18-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bald. C. Pagn. Cem.

Location Ind. Md.

18. Funeral director R. Perry

Address 1244 2 Leed Avenue

19. Feb 17 47 Dr. Kieffer
(Date recd. by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 16 47 6-30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____, 19____, to _____, 19____

and that I last saw h. _____ alive on _____, 19____

Immediate cause of death _____ DURATION _____

Acute Coroner failure

Due to Cardiovascular disease

Due to _____

Other conditions possible death

injury

(Include pregnancy within 8 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

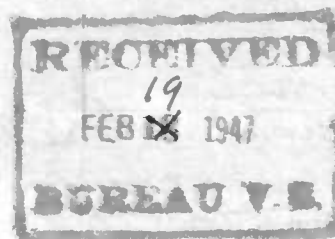
23. SIGNATURE Dr. M. Kieffer Dr. M. Kieffer

Address 1010 Leed Ave Date signed 2-16-47

MARGIN RESERVED FOR BINDING

VS 415

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01457 381

1. PLACE OF DEATH:

County Baltimore
 City or town Towson 4, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Since June 11 1943
 Hospital, institution, or street address where death occurred:
Eudowood Sanatorium, Towson 4, Md.
 How long in hospital or institution? Since June 20 1943

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 5137 Linden Heights Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war ☒

3. (a) FULL NAME

Minnie C Stengel
 4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife late John F. Stengel
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Dec 19 1864
 8. AGE: Years 82 Months 1 Days 15 If less than one day _____ hrs. _____ min.

9. Birthplace Germany
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business _____
 12. Name Joseph Kammer
 13. Birthplace Germany
 14. Maiden name _____
 15. Birthplace Germany

Personal History- Hospital Records

16. Informant _____
 Address Eudowood Sanatorium, Towson 4, Md.
 17. Funeral Date thereof 2/6/44
 (Burial, cremation, or removal, Which) (month) (day) (year)
 Cemetery or crematory Catholic
 Location 4309 Old Field Road
 18. Funeral director Bluff & Brown & Son
 Address 961-23 Hollins St
 19. 2/3 47
 (Date rec'd by registrar) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3 19 47 at 3 P M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 11 1943 to Feb 3 1947
 and that I last saw him alive on Feb 3 19 47
 Immediate cause of death Pulmonary Fibrosis
 DURATION 4 1/2 yr
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)
 Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE W A Bridges M.D. or other _____
 Address Towson 4, Maryland Date signed _____

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01458 8

Reg. Dist. No. 380

1. PLACE OF DEATH:

County Baltimore Co.
City or town Corney
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Harford Rd near Summit Ave
Stay in hospital or inst. (yrs., or mos., or days) _____
Stay in this community (yrs., or mos., or days) _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md County Baltimore Co.
City or town Corney Ward No. 11
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Harford Rd near Summit Ave
(If rural give LOCATION)
2(c) IF VETERAN, NAME WAR No

3. (a) FULL NAME

George J. Stroble

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

B (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) April 30, 1981

8. AGE: Years 65 Months 9 Days 12 hrs. _____ min. _____

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual occupation

none

11. Industry or business

12. Name George Stroble

13. Birthplace Baltimore, Md

14. Maiden name Margaret Ann Doyle

15. Birthplace Baltimore, Md

16. Informant Mr. Thomas J. Stroble

Address Harford Rd near Summit Ave

17. Burial Date thereof Feb. 15, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Matthews Cemetery

Location C Route 6 J

18. Funeral director Edward W Connelin, Son

Address 924 E. Eager St

19. 2-13-47 19 47 AW
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12, 1947 at 10:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 39 to Feb. 12, 1947
and that I last saw him live on Dec. 10, 1946

Immediate cause of death

Probable hypertensive cardio-vascular
Due to renal disease

Due to

Other conditions Fracture left hip (Healed - Dr. H. G. M.)
(Include pregnancy within 8 months of death)

Major findings:

Of operations _____

Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ injured at work?

23. SIGNATURE A. M. Bacon M. D. _____

Address 2810 Taylor Ave Date signed 2/12/47
Harold J. Muesio, M.D.

MARGIN RESERVED FOR BINDING

VSA15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PHYSICIAN
Please underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 381

1. PLACE OF DEATH:

County BaltimoreCity or town Fairson - North
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County BaltoCity or town North Fairson
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Charles H. Thompson

3. (b) Social Security Number

4. Sex M 5. Color or race C 6.(a) Single, married, widowed, or divorced M6.(b) Name of husband or wife Ella P.7. Birth date of deceased (mo., day, yr.) Dec. 20-1880 6.(c) If alive, give age _____ years8. AGE: Years 66 Months 2 Days 2 If less than one day _____ hrs. _____ min.9. Birthplace Baltimore Md.
(Town, county, and state)10. Usual occupation unemployed

11. Industry or business

12. Name Unknown13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant Ella P. ThompsonAddress North Fairson Md.17. Burial Date thereof 2-25-47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Frost HillLocation Balto. Co.18. Funeral director C. B. KladariAddress 2101 McElderry St.19. 2/24/47 H. W. Hedrick
(Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22 1947 at 5:00 a. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 8 47 to Feb 21 47
and that I last saw him alive on Feb 21 47

Immediate cause of death

Apoplexy
arterio-sclerosis
& hypertension

DURATION

24 hrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury

Injured at work?

23. SIGNATURE Thompson M.D.Address Fairson 4 - Md Date signed 2/22/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (U)

CERTIFICATE OF DEATH

Reg. Dist. No. 570

1. PLACE OF DEATH:

County Baltimore
 City or town Texas
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Texas
 (If outside city or town limits, write RURAL and give nearest town)

Street No. R.R. Ave
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Florence M. Thompson

3. (b) Social Security Number

4. Sex

F.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Thomas E. Thompson

7. Birth date of deceased (mo., day, yr.)

Sept. 22, 18776. (c) If alive, give age 71 years

8. AGE:

Years 69Months 4Days 20

If less than one day

hrs. min.

9. Birthplace

Balto. Co., Md.

(Town, county, and state)

10. Usual occupation

Homemaker

11. Industry or business

FATHER

12. Name

John Price

13. Birthplace

Balto. Co., Md.

MOTHER

14. Maiden name

Mary E. Fowler

15. Birthplace

Balto. Co., Md.

16. Informant

Mrs. Lloyd Pauls

Address

Texas, Md.

17.

Burial

Date thereof

Feb. 12, 1947

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Poplar Grove Church

Location

Cockeysville, Md.

18. Funeral director

Landen M. Brooks

Address

Sparks, Md.

19.

2-11

19

47Wilmer C. Ensor

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 9 1947 at 10:05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 41 1941 to Feb 9 1947and that I last saw him alive on Feb 9 1947

Immediate cause of death

Cerebral Hemorrhage

DURATION

2 hrs

Due to

Hypertensionunk

Due to

Arteriosclerosisunk

Other conditions

Diabetes Mellitus8 yrs

(Include pregnancy within 8 months of death)

Major findings of operations

none

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Bennett A. Stoen

M. D. or other

Address

HuthervilleDate signed 2/9/47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 13 1947

BUREAU

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 132

01462

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:

County Baltimore
 City or town Inner Harbor
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town _____
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Box 292 Route 3 Dundalk P.D.
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Katherine Tomaszewski (Chester)

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 8.(b) Name of husband or wife Joseph Tomaszewski (Chester) 6.(c) If alive, give age 60 years
 7. Date of death (mo., day, yr.) 1890

8. AGE: Years 36 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Poland
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Martin Dabrowski13. Birthplace Poland14. Maiden name Frances Farenba15. Birthplace Poland16. Informant Mr. Joseph TomaszewskiAddress Box 292 Route 3 Dundalk P.D.

17. Burial Date thereof 2-14-47
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St Stanislaus CemLocation Baltimore City18. Funeral director John M. WeberAddress 401 S. Chester Street

19. 2/12/47 19 47
 (Date rec'd by registrar) Registrar [Signature]

MEDICAL CERTIFICATION

11 45

20. DATE OF DEATH Feb. 10 19 47, at P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 19 45, to Feb. 10 19 47

and that I last saw him alive on Feb 10 19 47

Immediate cause of death

Myocarditis, Chronic

DURATION

10 years

Due to

Hypertension10 yrs

Due to

Arteriosclerosis10 yrs

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

2. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____

Injured at work? _____

23. SIGNATURE

David N. Andrew M.D.

M. D. or other

Address

2 Kingship Rd. Dundalk Md.Date signed 2/11/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. O'Donnell
7301 York Road

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-2)

CERTIFICATE OF DEATH

01463

Reg. Dist. No. 38

1. PLACE OF DEATH:
County..... Baltimore Parkville
City or town..... Baltimore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
2634 Wendover Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Maryland County..... 7 Parkville
City or town..... Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2634 Wendover Road
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME
Anna E. Trageser

3. (b) Social Security Number

4. Sex female **5. Color or race** white **6. (a) Single, married, widowed, or divorced** single
6. (b) Name of husband or wife
6. (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 2, 1883
8. AGE: Years 63 Months 8 Days 7 If less than one day hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual occupation st home
11. Industry or business
12. Name Peter E. Trageser
13. Birthplace Md.
14. Maiden name Margaret Hein
15. Birthplace Md.

16. Informant Mr. A. H. Goedeke
Address 2634 Wendover Road
17. Burial Date thereof 2/12/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Holy Redeemer
Location Baltimore, Md.
18. Funeral director Leonard J. Ruck
Address 5305 Harford Road
19. Feb 11 19 47 As per record Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9th, 19 47, at M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Sept 19 46, to Feb 9 19 47
and that I last saw h. alive on Feb 8 19 47
Immediate cause of death Heart Failure
Due to Rt. Ventricular Hemiplegia 2 Months
Due to Arteriosclerosis
Nephritis and Renal Stenosis 10 yrs
Other conditions
(Include pregnancy within 8 months of death)

Major findings of operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Dr. O'Donnell
M. D. or other
Address 7301 York Rd. Baltimore
Date signed 2/14/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (486)

CERTIFICATE OF DEATH

01464

Reg. Dist. No. 30

1. PLACE OF DEATH:

County BaltoCity or town Catonville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Good Nursing Home 5501 Emotion Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltoCity or town Balto
(If outside city or town limits, write RURAL and give nearest town)Street No. 621 Allendale St
(If rural, give LOCATION)2.(a) If veteran, name war ✓

3. (a) FULL NAME

Annie C. Tully

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Alfred Miles

7. Birth date of

deceased (mo., day, yr.)

Oct 4th 1866

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

80219hrs.min.

9. Birthplace

Balto. Md.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

At Home

MOTHER

FATHER

12. Name

William H. Busch

13. Birthplace

MD

14. Maiden name

Unknown

15. Birthplace

"

16. Informant

Mrs. Nettie Simering

Address

621 Allendale St

17.

(Burial, cremation, or removal. Which?)

Date thereof

2/26/47
(month) (day) (year)

Cemetery or crematory

Cedar Hill

Location

A. A. Co. Md.

16. Funeral director

William Cook Inc.

Address

1217 St. Paul St.

19.

(Date rec'd by registrar)

2-25-47Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 23rd

19

47 at 9 47 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 116.46to Feb 2319 47and that I last saw her alive on Feb 21st19 47

Immediate cause of death

Myocardial infarctionChronic hypertension & history of severalselected type heart disease &generalized atherosclerosis

Due to

Due to

Other conditions

Carcinoma of uterus8 months

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. Michel M.D.

M. D. or other

Address

2401 Chubberson Ave

Date signed

Feb 24 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01465 387

1. PLACE OF DEATH:

County Baltimore
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:
25 W. Penna. Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4516 Hampnett Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war ////

3. (a) FULL NAME

FLORENCE EDITH VAN HORN

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife Cornelius Lee Van Horn

7. Birth date of deceased (mo., day, yr.) October 3, 18 74 6.(c) If alive, give age 11 years

8. AGE: Years 72 Months 4 Days 19 It less than one day hrs. min.

9. Birthplace Baynesville, Balto. Co., Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At Home

12. Name Charles H. Bayne

13. Birthplace Maryland

14. Maiden name Laura V. Holland

15. Birthplace Maryland

16. Informant Miss Mary Bayne

Address 25 W. Penna. Ave., Towson, Md.

17. Burial Date thereof February 25, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Prospect Hill Cemetery

Location Towson, Maryland

18. Funeral director John Burnie Sons

Address Towson, Maryland

19. 2/25 19 47 H. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22, 1947 at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 15, 77 to Feb 15, 47 and that I last saw him alive on Feb 15, 47

Immediate cause of death Cerebral Aneurysm DURATION Sudden

Due to Arteriosclerosis Due to Septicemia

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John Burnie Sons M. D. or other

Address Towson, Md. Date signed 2/24/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

01466

300

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 yrs., 8 mos., 24 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 7 yrs., 8 mos., 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1535 McKean Street
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

John Varina

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) July 23, 1875

8. AGE: Years 71 Months 6 Days 25 It less than one day _____ hrs. _____ min.

9. Birthplace Maryland
 (Town, county, and state)

10. Usual occupation Laborer11. Industry or business Inspecting12. Name Edward Varina13. Birthplace Maryland14. Maiden name Susanne Hunter15. Birthplace Maryland16. Informant Hospital recordsAddress Catonsville-28, Maryland

17. Burial Date thereon Feb 21, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory WesternLocation Edmondson Ave18. Funeral director Chenoweth & SonovaneAddress 3615-17 Chestnut Ave.19. 2/19 47 A W Hedrick

(Date rec'd by registrar) _____ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 17 19 47 at 12:20 pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 24 19 39 to February 17 19 47

and that I last saw him alive on February 17 19 47

Immediate cause of death _____ DURATION

Chronic coronary sclerotic disease IndefiniteDue to Generalized arteriosclerotichypertensive cardiovascular-renalDue to disease " "Tuberculosis, pulmonary, caseous - over 2yrs.Other conditions Intertrochanteric fractureof right femur (old)

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results as above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Isadore Tuerk, M.D.

M. D. or other

Address Catonsville-28, Md.Date signed 2-18-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 18 days
 Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland
 How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1810 Jackson Street
 (If rural, give LOCATION)
 2(a) If veteran, name war World War I ✓

3. (a) FULL NAME

WAGNER, John Carl

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife _____
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) 1/16/99
 8. AGE: Years 48 Months - Days 30 It less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Maryland
 (Town, county, and state)
 10. Usual occupation Painter
 11. Industry or business _____
 12. Name Jacob Wagner
 13. Birthplace Germany
 14. Maiden name Lillian Michael
 15. Birthplace Baltimore, Maryland

16. Informant Clinical Records, Vets. Adm. Hosp.
 Address Fort Howard, Maryland

17. Burial Burial Date thereof 2-20-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Loudon Park Cemetery
Baltimore, Md.
 Location _____

18. Funeral director KACHAUSKAS FUNERAL HOME
 Address 703 McHenry St., Balto., Md.

19. Feb. 18 19 47 R. W. Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16, 1947 19 47 at 2:34 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 29, 1947 to February 16, 1947
 and that I last saw him alive on February 16, 1947

Immediate cause of death _____ DURATION
Lung Abscesses; rupture into
pleuro; pyo-thorax 6 Wks.
 Due to Unknown

Due to _____
 Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results Substantiated above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, pub'c place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Robert M. Cullison
R. M. CULLISON, M.D. CLIN. DIR.
 Address V.A.H. FORT HOWARD, MD. Date signed 2-17-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *4X*

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 DaysHospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, MarylandHow long in hospital or institution? 5 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 511 McMeachen Street
(If rural, give LOCATION)2. (a) If veteran, name war ✓

3. (a) FULL NAME

FRANK E. WASHINGTON

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	Colored	Widowed

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-4-1894

8. AGE:	Years	Months	Days	It less than one day
	52	4	1	hrs. min.

8. Birthplace Virginia
(Town, county, and state)10. Usual occupation Laborer

11. Industry or business

12. Name William Washington13. Birthplace Hampton, Virginia14. Maiden name Eliza Smith15. Birthplace Phoebus, Virginia16. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Maryland17. Burial Date thereof 2-10-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Hampton, Virginia18. Funeral director Charles R. LavoAddress 802 Mad. Ave.19. 2/2 X2 Ant. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5, 19 47 at 11:50a M21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 31, 19 47 to February 5, 19 47 and that I last saw him alive on February 5, 19 47Immediate cause of death Tuberculosis, pulmonary, chronic far advanced, active

DURATION

Unknown

Due to

Due to

Other conditions Tuberculous laryngitis 6 Weeks

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert M. Cullison

R.M. CULLISON, M.D. CLIN. DIR. other

Address V.A. FT. HOWARD, MD. Date signed 2-6-47

1947

1947

1947

1947

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01469

Reg. Dist. No. 301

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Dec 16 1876

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

70

2

10

hrs.

min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

None

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial, cremation, or removal, (Which?)

Date thereof

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

2-28-47

19-47

Harry V. Miller

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 26 1947 at 9:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 10 1939 to Feb. 25 1947

and that I last saw him alive on

Feb. 25 1947

Immediate cause of death

DURATION

Due to

Coronary Embolism
Cardio-Vascular Rupture1 hr.
8 yrs.

Due to

Cerebral Decompression

2 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

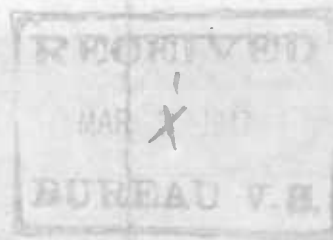
George E. Miller

M. D. or other

Address

Catonsville 28 Md

Date signed 2-27-47



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (6)

Reg. Dist. No. 320

CERTIFICATE OF DEATH

Be

01470

1. PLACE OF DEATH:

(a) County Baltimore
(b) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Appt Home Nursing Lane & Edman Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 months
(e) Length of stay in this community (yrs., mos., or days) 50 yr

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State MD (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 745 Patterson PK Ave. (If rural give location)
(e) If foreign born, how long in U. S. A.? ✓ years

3 (a) FULL NAME

ELIZA WEITZ

3 (b) If veteran, name war

3 (c) Social Security

No.

4. Sex

FA

5. Color or race

W.

6 (a) Single, married, widowed, or divorced

Widow

6 (b) Name of husband or wife

dean

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 26 1868

8. AGE: Years

79

Months

7

Days

2

If less than one day

hr.

min.

9. Birthplace

Germany
(Town, county, and state)

10. Usual occupation

None

11. Industry or business

MOTHER FATHER

12. Name

Fritz Reuback

13. Birthplace

Germany

14. Maiden Name

W. K. Kuntz

15. Birthplace

Germany

16 (a) Informant

Paul Weitz

(b) Address

745 N. Patterson PK Ave

17 (a)

Burial

(b) Date thereof

2/25/47

(c) Cemetery or crematory

Oak Hill

Location

Home Lane

18 (a) Funeral director

Christian Miller Son

(b) Address

2334 Jefferson St.

19 (a)

2/24/47

(b)

H. W. Kuntz

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. Date of death Feb. 22 1947, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 2 1946, to Feb 22 1947, and that I last saw him alive on Feb 22 1947.

Immediate cause of death

Arterio Sclerotic Cardiovascular Disease

Due to

Due to

Other conditions

Diabetes Mellitus

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy

Duration

1 yr

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature

Heinz Kuntz

M. D. or other

Address

Catonsville

Date signed

2/22

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(131-2)

CERTIFICATE OF DEATH

★ 01471

Reg. Dist. No. 301

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Eight days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? Eight days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Charles

City or town Waldorf
 (If outside city or town limits, write RURAL and give nearest town)

Street No. R. F. D. 1
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Benjamin Willett

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MaleWhiteWidower

6. (b) Name of husband or wife Elizabeth Acton

Deceased 6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) June 14 1867

8. AGE: Years Months Days If less than one day
79 8 4 _____ hrs. _____ min.

9. Birthplace Charles Co., Md.
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Agriculture

12. Name Richard Willett

13. Birthplace Maryland

14. Maiden name Rosella Hamilton

15. Birthplace Maryland

16. Informant Hospital Records

Address Catonsville, 28, Md.

17. Burial Date thereof 2/21/47
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Oakland

Location Waldorf, Md.

18. Funeral director Hunt & Ryan

Address Waldorf, Md.

19. 2-19 47 Harry D. Miller
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 18, 1947, 19 47, at 6:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 10, 19 47, to February 18, 19 47.

and that I last saw him alive on February 18, 1947.

Immediate cause of death

Chronic myocardial insufficiency

Due to Chronic hypertensive arterio-

sclerotic C-V-R disease

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

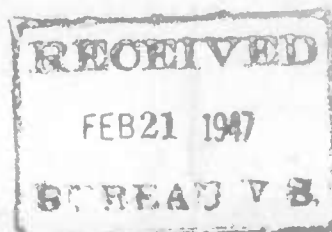
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Henry C. A. Mead M.D.

Address Catonsville, 28, Md. Date signed 2/18/47



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 300

1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

John W. Williams

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Caucasian

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Josephine Williams

7. Birth date of deceased (mo., day, yr.)

January 5, 1895

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

laborer

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

2-10-57

Cemetery or crematory

Location

18. Funeral director

Address

19. 2-8

(Date rec'd by registrar)

19 47

A. W. Hedrick

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

md

County

Baltimore

City or town

Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

N. Paradise Rd

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb - 74

19

47, at 1.45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 94

19

46 to Feb 74

19

47

and that I last saw him alive on

Feb 74

19

47

Immediate cause of death

Cirrhosis Liver

DURATION

Due to

Chronic. Duration three or four years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

C. F. Maloney M.D.

M. D. or other

Address

Catonsville Md

Date signed

STATE OF MARYLAND—CERTIFICATE OF DEATH

01473 P

1. PLACE OF DEATH

County BaltimoreVillage or City White Marsh Md.No. Henry J. Campbell Plant Ward

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

2. FULL NAME

(a) Residence: No.

504 Orchard St.

St.

Ward

Baltimore Md.

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Caucas5. SINGLE, MARRIED, WIDOWED,
OR DIVORCED (write the word)Married

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE ofRoberta Williams

6. DATE OF BIRTH (month, day, and year)

Nov 27, 1901

7. AGE

Years

Months

Days

If LESS than
1 day, ----- hrs.
or ----- min.45

OCCUPATION

8. Trade, profession, or particular
kind of work done, as SPINNER,
SAWYER, BOOKKEEPER, etc.Laborer9. Industry or business in which
work was done, as SILK MILL,
SAW MILL, BANK, etc.10. Date deceased last worked at
this occupation (month and
year)Feb 8, 194711. Total time (years)
spent in this
occupation12. BIRTHPLACE (city or town)
(State or country)Lynchburg Va.

FATHER

13. NAME

Meris Williams14. BIRTHPLACE (city or town)
(State or country)Lynchburg Va.

MOTHER

15. MAIDEN NAME

Jennie Custer16. BIRTHPLACE (city or town)
(State or country)Lynchburg Va.

17. INFORMANT

(Address)

Roberta Williams
504 Orchard St.

18. BURIAL, CREMATION, OR REMOVAL

Place

Elbridge Md.

Date

Feb. 12, 1947

19. UNDERTAKER

(Address)

Mrs. Kate R. Williams
322 N. Schreiner St.

20. FILED

Nov

47

19

Baltimore

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

(Month)

(Day)

(Year)

Feb 8, 1947

22.

I HEREBY CERTIFY, That I attended deceased from

, 19

, to

, 19

I last saw h

alive on

, 19

; death is said

to have occurred on the date stated above, at

The PRINCIPAL CAUSE OF DEATH and related causes of importance
were as follows:Coronary occlusion

Date of onset

Immediate

Other Contributory Causes of Importance:

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide?

Date of Injury

, 19

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

(Address)

M. D.

Dr. M. J. Williams
Deputy Medical Examiner
Baltimore Md.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
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Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 01474
30

1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)Street No. 5313 Edmonson Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

3.(b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Widow6.(b) Name of husband or wife unknown

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) June 29, 18678. AGE: Years 79 Months 7 Days 5 If less than one day _____ hrs. _____ min.9. Birthplace Harford Co. Md.
(Town, county, and state)10. Usual occupation none

11. Industry or business

12. Name unknown13. Birthplace "14. Maiden name "15. Birthplace "16. Informant Balto Co Welfare BoardAddress Jarvison Md.17. Burial Date thereof 2-6-47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Good ShepherdLocation Ellicott City, Md.18. Funeral director J.C. NijmboothsAddress Ellicott City, Md.19. 2-5 47 Harry J. Miller
(Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 4 1947, at 6 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10 1947 to Feb 4 1947
and that I last saw him alive on Feb 2 1947Immediate cause of death Cor Myocarditis

DURATION

1 monDue to Arterio Sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE James H. Stowers

M. D. or other

Address CatonsvilleDate signed 2-5

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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BUREAU # 8

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

 01475
 Reg. Diat. No. 301

1. PLACE OF DEATH:

 County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Hood Nursing Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

 State Md. County Montgomery

 City or town Tacoma Park
 (If outside city or town limits, write RURAL and give nearest town)

 Street No. 403 Boyd Avenue
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Sarah A. Wilson

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

Joseph J.

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Dec. 6, 1863

8. AGE:

Years

83

Months

2

Days

22

If less than one day

hrs.

min.

9. Birthplace

Pennsylvania

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Reuben Sterner

13. Birthplace

Pennsylvania

MOTHER

14. Maiden name

Mary A. Shbaugh

15. Birthplace

Pennsylvania

16. Informant

Mrs. Lucile McLean

Address

403 Boyd Ave., Tacoma Park Md.

17.

(Burial, cremation, or removal. Which?)

Cremation

Date thereof

March Feb. 2 1947

(month) (day) (year)

Cemetery or crematory

Fort Lincoln Cemetery

Location

St. Bladensburg, Md.

18. Funeral director

William J. Tickner & Sons

Address

North & Pennsylvania Aves

19.

(Date rec'd by registrar)

19.

473-1-47Harry H. MillerDeputyRegistrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 2847 12-15-A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 20 1947, to Feb 28 1947and that I last saw him alive on Feb 27 1947

Immediate cause of death

Chronic Myocarditis

DURATION

3 months

Due to

Arteriosclerosis

Due to

Other conditions

Pneumo Pneumonia

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

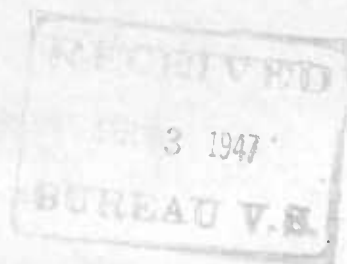
23. SIGNATURE

James Howell

M. D. or other

Address Tacoma Park Date signed 2-28

May
Alb. S. Lowell
715 Hudson Ave.



1-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

01476

Reg. Dist. No. 37

1. PLACE OF DEATH

County Baltimore

City or town Cockeysville Ind
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, institution, or street address where death occurred

Masonic Home, Cockeysville Ind

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Baltimore

City or town MD
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5218 Beaufort Dr

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME

Henry Windus

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Anna Maria Windus

8.(c) If alive, give age 86 years

7. Birth date of deceased (mo., day, yr.) Oct. 11 - 1859

8. AGE: Years 87 Months 3 Days 25 If less than one day

hrs. min.

9. Birthplace Baltimore Ind
(Town, county, and state)

10. Usual occupation Machinist

11. Industry or business

12. Name John Windus

13. Birthplace Germany

14. Maiden name Don't know

15. Birthplace "

16. Informant Laura M. Schroeder

Address Masonic Home, Cockeysville

17. Burial Date thereof Feb 8 - 47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory London Park

Location Baltimore Ind.

18. Funeral director Wm. Cook

Address St Paul & Preston St

19. Feb 6 19 47 L.M. Schroeder
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6 19 47 at 11:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19.47 to Feb 6 19 47

and that I last saw him alive on Feb 6 19 46

Immediate cause of death Heart failure

DURATION

2 days

Due to Arteriosclerosis 6 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter T. Kees M.D.

Address Cockeysville Ind. Date signed

MARGIN RESERVED FOR BINDING

VS A15-1 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01477

Reg. Dist. No. 310

1. PLACE OF DEATH:

County BaltimoreCity or town Rockdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

8401 Liberty Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Rockdale
(If outside city or town limits, write RURAL and give nearest town)Street No. 8401 Liberty Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

DAVID FRANK ZEIGLER

3.(b) Social Security Number

215-01-0652

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Edith M. Zeigler

6.(c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

March 17, 1872

8. AGE:

Years

74

Months

10

Days

20

If less than one day

..... hrs. min.

9. Birthplace Montgomery Co., Md.

(Town, county, and state)

10. Usual occupation Vice President11. Industry or business Home Friendly Ins. Co.12. Name David W. Zeigler

13. Birthplace

Md.

MOTHER

14. Maiden name Macelfresh

15. Birthplace

Md.16. Informant Mrs Edith M. Zeigler

Address

8401 Liberty Rd. Balto. 7, Md.17. Burial Date thereof 2/11/47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Lorraine MausoleumLocation Woodlawn Cem.WM. J. TICKNER & SONS18. Funeral director Balto., Md.

Address

2/8/47 W. E. Martin
19. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7, 19 47 at 11:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1946 to Feb. 7, 1947
and that I last saw him alive on Feb. 7, 1947

Immediate cause of death

Carcinoma of Transverse Colon

DURATION

Due to

Due to

Other conditions

Diabetes nephrotis & Myocarditis
(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE W. E. Martin M. D. or otherAddress Randallstown Date signed 2/8/47

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92

CERTIFICATE OF DEATH

Reg. Dist. No. 01478

1. PLACE OF DEATH:

County Balto.
 City or town Texas Ind.
 (If outside city or town limits, write RURAL NEAR and give town)
 Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore
 City or town Texas Ind. Ward No.
 (If outside city or town limits, write RURAL NEAR and give town)
 Street No. 2401 Bld.
 (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME

Georgianna Zimmerman

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

female white Widowed

6. (b) Name of husband or wife Wm. H. Zimmerman

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10 1865

8. AGE: Years 81 Months 8 Days 16 If less than one day
 hrs. min.

9. Birthplace Pharmacia Ind.
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Home12. Name John Price13. Birthplace Ind.14. Maiden name Mary Fowler15. Birthplace Ind.16. Informant Blair D. PriceAddress Texas Ind.

17. Burial Date thereof 2 9 47
 (Burial, cremation, or removal) (month) (day) (year)

Cemetery or crematory Poplar Grove MethodistLocation Warren Co. Ind.18. Funeral director Langdon M. BroadAddress Sparks, Ind.

2-5 47 Wilmer C. Ensor

19. (Date rec'd by registrar) 19- Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5 - 19 47, at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Oct 15 - 19 40, to 2/5 - 19 47
 and that I last saw her alive on 1/30 - 19 47

Immediate cause of death Coronary Thrombosis DURATION 1 hr.Due to Myocarditis 3 yrs.Due to Arteriosclerosis

Other conditions

Major findings: Of operations

Of autopsy

(Include pregnancy within 3 months of death)

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Wilmer C. Ensor M.D. M. D. or otherAddress Cockeysville Md. Date signed 2/5/47

MARGIN RESERVED FOR BINDING

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PHYSICIAN

Please underline
 the cause to which
 death should be
 charged statisti-
 cally.

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FEB 7 1947

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